Public consultation - Submission

Health checks for late career doctors

7 August 2024
The Medical Board of Australia is now consulting on a proposal to introduce health checks for late career doctors.
The Consultation Regulation Impact Statement (CRIS) released by the Board seeks feedback on whether additional safeguards are needed for late career doctors (aged 70 years and older) to manage their health, including whether late career doctors should be required to have regular health checks so they can make informed decisions about their health and practice and manage the related risk to patients. The CRIS provides a summary of the Board's assessment of the impact and costs and benefits of each option.

This submission form is intended for organisations, registered health practitioners, patients and consumers.
The consultation paper, including the supporting documents, is available on the Board's website.
Submissions can be emailed to medboardconsultation@ahpra.gov.au.
The closing date for submissions is 4 October 2024.

Publication of submissions

Published submissions will include the names of the individuals and/or the organisations that made them, unless confidentiality is expressly requested.

Your details
Name: Associate Professor Geoffrey Hawson
Organisation (if applicable): Australian Senior Active Doctors Association Inc.
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 ☒ Yes, with my name ☐ Yes, without my name ☐ No, do not publish my submission

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. The MBA proposal is age discriminatory and is not supported by the information contained in the CRIS document which reveals selective reporting of data and references and misrepresentation of findings. Notifications (unsubstantiated complaints) are used in a way that exaggerates the issue, is misleading to the profession and the public, and undermines confidence in late career doctors.

Overall, our analysis reveals that a very small percentage of late career doctors are subject to complaints (notifications) that lead to regulatory action. The mandatory imposition of health and cognitive assessments for all late career doctors is unwarranted and likely to lead to professional stress and underperformance on tests. Cognitive tests lack norms for doctors and there are questions around which cut off scores are appropriate. Highly experienced senior doctors are likely to leave the profession, exacerbating the current and projected medical workforce shortage. Given that there are mechanisms currently in place to address impaired practice in doctors of all ages, there is no need to introduce mandatory assessments.

A recent Senate inquiry into notifications management by Ahpra reveals the devastating impact on doctors who are the target of unfounded complaints:

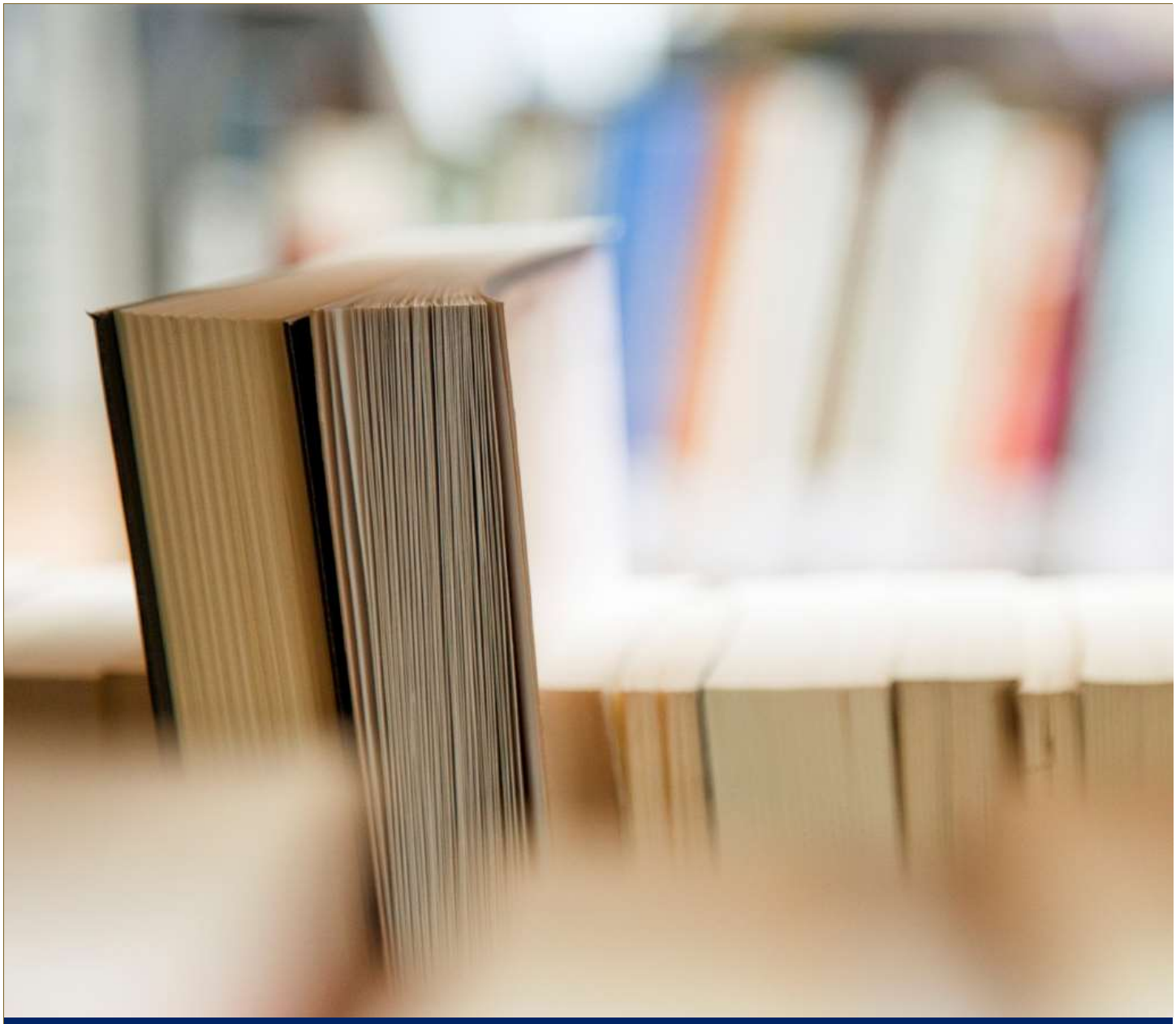
> 'The committee heard that the impact the notifications process has on the health and wellbeing of practitioners is disproportionate to the risk to public safety.'

Publishing and reporting of unsubstantiated complaints in ways that exaggerate issues (e.g., relative rates without absolute numbers), as in the CRIS document, undermines public confidence in late career doctors, causes professional stress, misleads the public and the profession, and perpetuates ageist stereotypes. There is potential for mandatory assessment results to be used in harmful and vexatious ways.

I attach a detailed analysis of the information contained in the CRIS document. The issues identified include:

1. Unsubstantiated complaints (notifications) are not evidence of impairment and should not be used to imply impairment.
2. Biased reporting of notifications data.
3. Failure to acknowledge that a high majority of complaints do not lead to regulatory action.
4. Use of relative ratios without reference to absolute numbers and differences.
5. A problematic reliance on Thomas et al.
6. Failure to scrutinise references used to argue impairment in late career doctors, along with misrepresentation of findings from research articles.
7. The omission of the higher notification risk for IMGs and misrepresentation of their results as age-related.
8. Institutional ageism.
9. Problems with the validity of cognitive testing and the impact of Age Based Stereotype Threat on testing performance.

Note: answers to Questions 2 onwards are provided on page 30 after the analysis.



Australian Senior Active Doctors Association Inc

Submission on the Medical Board Ahpra Consultation Regulation Statement: Health Checks for Late Career Doctors

Associate Professor Geoffrey Hawson
President

Australian Senior Active Doctors Association Inc.
Submission on the Medical Board Ahpra Consultation Regulation Impact Statement (CRIS): Health Checks for Late Career Doctors

The Medical Board of Australia (MBA) has recommended that late career doctors aged over 70 have a regular 3 yearly 'health check' and annually for those over 80. Their argument is that older doctors show 'cognitive impairment' as evidenced by rates of notifications or unsubstantiated complaints. Health checks are to include cognitive assessment.

The MBA proposal is age discriminatory and is not supported by the information contained in the CRIS document which reveals selective reporting of data and references. The CRIS document uses notifications data in a way that exaggerates the issue, is misleading to the profession and the public, and undermines confidence in late career doctors.

ASADA does not support the MBA recommendation and supports Option 1, the status quo.

The Medical Board Ahpra CRIS document reveals a range of errors and biases in the portrayal of late career doctors that mislead the profession and the public. We provide a summary of our analysis below and a more detailed analysis in the sections which follow.

- **Unsubstantiated complaints (notifications) are not evidence of impairment.**

  A number of reviews of Ahpra, along with a recent Senate Committee Inquiry, show systemic problems with Ahpra processes and raise questions about the validity and reliability of Ahpra notifications data and their categorisation (see Section 1.3). There is no publicly available information on how notifications are categorised at the time of complaint and whether there is consistency in definition or meaning, or congruence between complainant and coder.

  While it is important to have a complaints process, notifications remain unsubstantiated until the concerns are assessed and if necessary, further investigated. A complaint in itself is not evidence of impairment or any other behaviour or condition and it is misleading to imply levels of impairment from numbers of complaints and rates of complaints

  The MBA CRIS document confounds the notion of impairment with cognitive decline. Instances of impairment in any age group can arise for a number of reasons and not necessarily cognitive decline. It is an ageist argument to claim that numbers of unsubstantiated complaints for late career doctors are evidence of cognitive decline but notifications in doctors under 70 are not, particularly when cognitive impairment can occur at any age.

- **Biased reporting of notifications data**

  The notifications process captures large numbers of unsubstantiated complaints. Yet they are often reported without caveat, regardless of the level of veracity, and regardless of the outcome of the complaints. They are analysed by authors working in the public health and regulation area and published without context. The use of relative risk ratios to describe group differences is known to statistically inflate the prevalence of issues, particularly when applied to small numbers.

  This approach to 'data' and 'data analysis' is concerning and warrants far more scrutiny from the medical and academic communities. A more objective approach to data analysis from an

independent researcher perspective is required rather than as Bismark et al.[1] admit: 'Our study adopted a regulator's perspective' (p.879), or Thomas et al.[2]: 'Partnerships between researchers and regulators can enable new insights into patient safety risks and inform regulatory practices'. The concern is that the data analyses show a bias to the regulator and may be used as support for policy decisions that have already been made.

The CRIS document claims that the number of complaints against late career doctors has been rising since 2015. We show in Section 2 of our detailed analysis that this is misleading as complaints have been rising for all doctors, all health practitioners, and for Ahpra itself, and that this is consistent with national and international trends. In light of this, to imply that an increase in complaints against late career doctors is unique and due to impairment is grossly misleading and denies the context and range of reasons for increasing complaints, such as population growth and ageing, new and emerging health concerns, expansion on the types of health services and alternative therapies, greater consumer expectations and access to medical information through the internet and social media, and awareness of complaints bodies.

We find inconsistencies in the numbers for categorised notifications between the CRIS document and the Ahpra Annual Report Tables (see Section 2); biased presentation of data in the CRIS document in regard to numbers of notifications and rates; reporting of relative rates without reference to absolute numbers or frequencies; and a failure to distinguish between the number of notifications and the number of doctors with a notification. All of these mean that the document provides a skewed and incomplete picture.

- **The majority of complaints do not lead to regulatory action**.

The annual reports published by Ahpra (Australian Health Practitioner Regulations Authority)[3] and the Health Care Complaints Commission[4] (HCCC, NSW) show that the vast majority of complaints (approx. 80%) do not result in further action (see Section 1.1) The MBA Ahpra proposal is misleading in not acknowledging this. For 2023, 5.7% of doctors nationally had complaints made about them and around 80% of these complaints led to no action, either at first assessment or subsequently.

The CRIS document reports there were 485 complaints with Ahpra for doctors aged 70 and over in 2023. With an average rate of 1.25 complaints per doctor with a complaint (Ahpra Annual Report 2023), we estimate approximately 388 doctors aged 70 and over had complaints with Ahpra. This represents 5.56% of the 6,975 registered doctors aged 70 and over (excl. non-practising registration). Approx. 77% of the complaints did not lead to action (CRIS). The data for late career doctors is similar to that for all doctors.

- **Use of relative risks without reference to absolute risk and absolute numbers.**

The medical profession is aware of the problem that arises when trial results are reported as relative ratios without the absolute and base numbers of individuals treated. The MBA's use of relative ratios obscures the fact that there are many more (absolute) complaints in the much larger, under 70 group despite having a lower relative rate (see Table 4).

Reporting relative rates of unsubstantiated complaints without reference to absolute numbers and outcomes serves to grossly overstate issues. For example, of what meaning is it to know that unsubstantiated complaints for one group are 1.7 times that of another group, if we know nothing of the veracity of the complaints, or the actual outcome of the complaints?

The CRIS document uses relative risk ratios to describe group differences. This is known to statistically inflate the prevalence of issues, particularly when applied to small numbers.

Our analysis shows that the argument in the CRIS document is not supported by the data. We summarise key findings below:

- The under 70 group includes a cohort of young doctors whose employment context (e.g., hospitals) may mean that notifications to Ahpra are less likely. Hence comparing a large cohort of 125,391 doctors (<70) with a much smaller cohort of 6,975 doctors (≥70) obscures age group differences in the under 70 group. It may also understate notification rates in the large group because averages are reduced by the younger cohort.
- In 2023, there were 485 complaints with Ahpra for doctors aged 70 and over, compared with approximately 5,030 complaints for doctors under 70 (see Section 2.2).
- In absolute terms, approx. 8.6% of notifications with Ahpra were for doctors over 70, while the vast majority (91.4%) were for doctors under 70.
- Of the 485 complaints for late career doctors, 113 led to regulatory action comprising *caution*, *accept undertaking* and *impose conditions*. No information is provided in the CRIS document on the types of notifications leading to regulatory action.
- The MBA CRIS document provides data on notifications but does not provide information on the number of doctors with notifications in the over 70 group nor for doctors in the under 70 group. Because there can be more than one notification per doctor, the use of notifications data alone tends to inflate in the readers mind the number of doctors involved.
- Using the Ahpra Annual Report (2023) average of 1.25 complaints per doctor with a complaint, we estimate that approximately 90 late career doctors were the subject of regulatory action with an estimated 58 having conditions imposed.
- Fines, reprimands, and suspension of registration, more stringent actions, did not occur for doctors aged 70 and over although they did for doctors under70.
- There were 6,975 doctors aged ≥70 registered in 2023 (excl. non practising registration). We estimate that 90 doctors represent 1.29% of the total number of late career doctors.

- **Problematic reliance on Thomas et al.**

  The MBA has emphasised the results of Thomas et al.[2] in the CRIS document and in media releases claiming that late career doctors are 15.54 times more likely to receive a complaint relating to *physical illness/cognitive decline*. There are a number of concerns with the reporting in this article, including the use of relative ratios on small numbers and the underlying assumptions (see Section 6 for details). Inclusion of other findings from the study show a different picture:

  - 86.8% of doctors over 65 did not receive a notification during the 4-year target period (2010-2014) compared with 84.2% of doctors aged 36-60 years.
  - A higher percentage of doctors aged 36-60 (15.8%) received a notification than doctors aged over 65 (13.2%) (Significantly different, p<.01, but not reported in the document). 8.5% of notifications for all doctors led to regulatory action. 91.5% did not.
  - Categorisation of complaints as *physical illness/cognitive decline* did not differentiate between the two; it is not known what percentages are attributable to each.
  - 4.5% of the complaints for doctors over 65 were categorised as *physical illness/cognitive decline*. There were 72 notifications for *physical illness/cognitive* decline for the group of 7,627 doctors over 65. If 72 notifications refer to 72 unique doctors, then 0.98% of doctors over 65 received a complaint related to *physical illness/cognitive decline.* For doctors aged 36-60, there were 45 notifications (0.4%) categorised as *physical illness/cognitive decline.*
  - 3.4% of the complaints for doctors aged 36-60 were for *mental illness and substance misuse* with an estimated 388 doctors receiving a complaint. There were 24 notifications (1.5%) for doctors over 65 for *mental illness and substance misuse*.

- **Given the much larger number of doctors in the younger group who had notifications related to *mental illness and substance abuse*, and if public safety is the primary concern of the regulator, why not introduce mandatory drug testing for younger doctors? Or psychiatric assessments for this group?**

Given the emphasis on health impairment rates in the CRIS document, it is important to note that the 2023 data on *health impairment* notifications shows a reduced percentage of notifications for late career doctors, compared with Thomas et al., and an increase in notifications for doctors under 70. There were approximately 18 notifications for *health impairment* for doctors aged ≥70 and 79 for those under 70 (see Table 4). No information on the number of doctors who had a *health impairment* complaint and the number of *health impairment* complaints leading to regulatory action is provided in the CRIS document.

- **Failure to properly scrutinise references used to argue impairment in late career doctors.**

The CRIS document fails to properly scrutinise references used to argue for impairment in late career doctors and has omitted studies that support a different perspective. Indeed, there are a number of examples of misquoting results from the references used in the document in order to further a stereotyped argument about late career doctors (see Section 8). This is very concerning and reflects a failure of the author/s of the document to understand the papers they have summarised. A number are dated (over 20 years old) and/or refer to small numbers. Many are written from a regulator's perspective[1,2,5,6]. Some authors are on medical boards or medical indemnity insurers with a potential bias.

The paper by Choudhry et al. is of inferior quality in terms of assumptions, data selection, analysis, and deductions. The claim is that the article shows cognitive impairment with age in doctors when, in fact, the meta-analysis did not address cognitive impairment at all (Section 6).

Another example is the Kataria[6] et al. study on cognitive function in 109 practitioners (doctors & dentists) over the age of 45 years. The reporting of the results in the CRIS document omits key information on the characteristics of the doctors, that 50% of those with a low score were below age 60 and that a majority (95%) were international medical graduates (IMGs), suggesting that increasing age is not the reason for 'cognitive impairment' in the sample. Indeed, the authors note:

> "Given that the majority of those scoring ≤88 did not possess English as their primary language, this raises questions about how it effects the validity and reliability of ACE-R which was designed with native English speakers in mind, or at least those who speak English fluently." (p.5)

- **International Medical Graduates (IMGs) have a higher notification risk.**

The CRIS document does not acknowledge the increased risk of notifications concerning IMGs even though four of the MBA CRIS references that are used to show 'impairment' in older doctors, actually report an increased notification risk for IMGs. To claim that these studies support age-related cognitive decline is misleading. We do not suggest targeting IMGs but wonder why these results have been omitted in the CRIS document (see Section 7).

- **Institutional Ageism**

A concerning feature of the CRIS document is the level of ageism that is inherent in its portrayal of late career doctors. Many of the statements around health and cognitive impairment are not borne out by current research and serve to perpetuate the stereotype of older age as synonymous with impairment. The WHO Global Report on Ageism[7] finds that 'ageism is prevalent, deeply ingrained and more socially accepted than other forms of bias' and that 'globally, one in two people are ageist against older people'. Age discrimination

commissioner Kay Patterson[8] calls ageism "the least understood form of discriminatory prejudice" and "more pervasive and socially accepted than sexism and racism". We note the following comment by Barber[9]:

> "aging stereotypes have actually become more negative in recent years … we "are edging closer to accepting a new stereotype that cognitive function falls off in midlife". In accepting this stereotype as truth, we may be spreading an "epidemic of fear"… in which the current generation of older adults is experiencing heightened concern about their own abilities as they age."

Institutional policies and practices that perpetuate stereotypical beliefs about older people constitute 'institutional ageism'[7] and, if left unchecked, drive ageist policies.

- **Cognitive testing**

The growing evidence shows that there is no stable basis for arguing that cognition necessarily declines with chronological age and that, in measuring cognitive resources, one must be clear about the abilities being measured, how they are measured, the people they're being measured in, and what their relevance is to practice. Many researchers are adopting the premise that cognitive ageing is biologically-driven rather than chronologically-driven and that explanations and measurements of cognitive changes are under-developed at this time. Rather than promulgating a deficit model of cognitive resources, there is growing research on how cognitive resources are maintained and enhanced with appropriate lifestyle and health choices across the lifespan.

There is clear evidence that older adults' memory and cognitive performance is negatively affected by threat from age stereotypes, and that these effects persist across gender and age groups (within later life)[10]. The effect of Aged Based Stereotype Threat (ABST) has been documented for over a decade with research showing that older people can be vulnerable to ABST when they perform memory, cognitive, or physical tests, with the result that they underperform. Mandatory testing is likely to exacerbate underperformance, particularly when the testing is seen as punitive and used to establish baselines against which future performance is to be measured, as in the MBA recommendation. Distinguishing between underperformance due to impairment and underperformance due to ABST is problematic.

In relation to the MMSE, the CRIS document states, "A study of older people with greater education showed a MMSE score of less than 28 was more sensitive in detecting impairment than the standard threshold of 23 or less". The reference by O'Bryant [11], both in the conclusion and text, in fact uses a cutoff score of 27 meaning 26 or lower - "This cutoff has an optimal balance between sensitivity and specificity". The CRIS document argues for the use of MMSE and the ACE-III and in the case of the former using higher cutoff scores to diagnose impairment. The CRIS document misrepresents the cutoff score for the MMSE in the O'Bryant article. Using a non-validated cut off score to screen doctors is highly problematic. There are no established norms for medical doctors for the MMSE or ACE-III.

- **Conclusion**

Overall, our analysis reveals that a very small percentage of late career doctors are subject to complaints (notifications) that lead to regulatory action. The mandatory imposition of health and cognitive assessments for all late career doctors is unwarranted and likely to lead to professional stress and underperformance on tests. Cognitive tests lack norms for doctors and there are questions around which cut off scores are appropriate. Highly experienced senior doctors will leave the profession, exacerbating the current and projected medical workforce

shortage. There are currently mechanisms in place to address impaired practice in doctors of all ages.

A recent Senate inquiry into notifications management by Ahpra reveals the devastating impact on doctors who are the target of unfounded complaints:

> 'The committee heard that the impact the notifications process has on the health and wellbeing of practitioners is disproportionate to the risk to public safety.'

Publishing and reporting of unsubstantiated complaints in ways that exaggerate issues (e.g., relative rates without absolute numbers), such as in the CRIS document, undermines public confidence in late career doctors, causes professional stress, misleads the public and the profession, and perpetuates ageist stereotypes.

Detailed Analysis of the MBA Ahpra CRIS Statement

1. Unsubstantiated complaints are not evidence

1.1. Notifications do not lead to action in the majority of cases

- The proposal relies on the number of notifications, or unsubstantiated complaints, to argue for impairment in medical practitioners over 70. It is well documented in the annual reports published by Ahpra (Australian Health Practitioner Regulations Authority)[12] and the Health Care Complaints Commission[13] (HCCC, NSW) that the vast majority of complaints do not result in further action. The MBA proposal is misleading in not acknowledging this.
- The right to make a complaint and provide feedback is included in the Australian Charter of Healthcare Rights. While it is important to have a complaints process, notifications remain unsubstantiated until the concerns are assessed and if necessary, further investigated. A complaint in itself is not evidence of impairment or any other behaviour or condition and it is misleading to imply levels of impairment from numbers of complaints and rates of complaints.
- The Ahpra Annual Reports for 2023[14] shows that, nationally, only 5.7 % (2022: 6.2%, 2021: 5.7%) of all registered doctors were 'with notifications' or had complaints against them, therefore 94.3% did not have a complaint.
- The MBA CRIS document fails to inform readers that between 70% and 85% of complaints (depending on the data source and year) do not lead to any action and are discontinued. This occurs for complaints to Ahpra and to the HPCA (Health Professional Councils Authority, NSW).
- The HCCC 2023 Annual Report[15] for NSW (p.37) indicates that for medical practitioners:
  - 'the most common outcome of an assessment was to discontinue the complaint and this was the outcome for 64.5% of complaints. A further 15.9% were discontinued with Comments. Together these categories made up 80.4% of outcomes'...
  - 'The 107 complaints about medical practitioners that were referred for investigation constituted 3.4% of complaints about medical practitioners' … 'lower than the proportion for all health practitioners (6.8%)'.

1.2. Unsubstantiated complaints are not valid data

- Unsubstantiated complaints or notifications are used as evidence for 'impairment' in the CRIS document and, indeed, in a number of the references used as support.
- Why complaints should not be used in this way.
  - Numbers of notifications and rates of notification generally have little connection with actual practice for the vast majority of doctors of all ages. Only 5.7% of doctors nationally had complaints made about them in 2023 and around 80% of these complaints led to no action.
  - The National Law sets out the processes by which notifications may be made about a registered health practitioner. As a regulatory authority, Ahpra's legislated brief is to provide mechanisms for capturing and managing such complaints. Ahpra reports complaints data, investigations, outcomes, timelines for investigation and completion, and so on, as part of their organisational performance reporting and establishes KPIs around these.
  - The complaints process captures large numbers of unsubstantiated complaints, or 'unsubstantiated allegations' (Ahpra Regulatory Operations Guide[16]). Yet they are often reported without caveat, regardless of the level of veracity, and regardless of the outcome of the complaints. They are analysed by authors working in the public health and regulation area and published as though they are meaningful. This field of reporting has relied on

unsubstantiated complaints and relative risk ratios to describe group differences. The use of the latter is known to statistically inflate the prevalence of issues, particularly when applied to small numbers.

- This approach to 'data' and 'data analysis' is concerning and warrants far more scrutiny from the medical and academic communities. What is required is a more objective approach to data analysis from an independent researcher perspective rather than as Bismark et al.[1] admit: 'Our study adopted a regulator's perspective' (p.879), or Thomas et al.[2]: 'Partnerships between researchers and regulators can enable new insights into patient safety risks and inform regulatory practices'. The concern is that the data analyses show a bias to the regulator and may be used as support for policy decisions that have already been made.
- A recent Senate Community Affairs References Committee[17] (2022) inquiry found a number of systemic issues with notifications handling and that it 'is stressful for health practitioners and can have a detrimental impact on their health, reputation and livelihood':

  'there is a significant amount of stress involved in the notifications process for practitioners. This is unduly exacerbated by a range of issues with the process, including how regulators communicate with parties, a lack of understanding and transparency about the process, and of course, because of protracted timeframes and delays'

  'The committee heard that the impact the notifications process has on the health and wellbeing of practitioners is disproportionate to the risk to public safety.'

- Publishing and reporting of unsubstantiated complaints in ways that exaggerate issues (e.g., relative rates without absolute numbers), such as in the CRIS document, undermines public confidence in late career doctors, causes professional stress, and perpetuates ageist stereotypes.

1.3. Potential issues with categorisation of notifications

- It is also unclear whether there is consistency in how notifications (unsubstantiated complaints) are categorised and whether there is consistency across Ahpra staff and across the years of data collection. In order to make meaningful comparisons over time and across subgroups, the data needs to be accurate. It must be emphasised that the notifications data presented in the CRIS document is not the result of a well-designed research study where the methodology around categorisation has been scrutinised by research or ethics committees to assess, for example, the appropriateness of category definitions and meaning. There is no guarantee of consistency in methods of notifications categorisation and collection across time, as this is not reported. There are no reports of the inter-rater reliability for staff on notifications teams, for example.
- The Ahpra Regulatory Guide[18] states that 'Notifications may be made to Ahpra verbally, including by telephone; or in writing, including by email or other electronic means.' 'If a notification is made verbally, Ahpra must make a record of the notification.'
- How is a recorded notification categorised? A list of issues is used to categorise complaints and are reported in the supplementary tables of Ahpra's Annual reports (see list below). The 2023 N1 supplementary table[19] notes contain the following information: 'The issue categorisation is based on initial information provided by the notifier. An issue category is not always identified by the notifier.' It appears that notifications are categorised at the time of initial complaint. A category may be identified by the complainant or identified by staff. There is no information on how a category is arrived at or whether the category has the same meaning for the complainant and the staff member. Neither the Ahpra Regulatory Operations Guideline[16] (2018) nor the Ahpra Regulatory Guide[18] (2024) provide advice on the categorisation process at the time of receiving the complaint nor the definitions of the categories listed in Table 1.

Table 1. List of categories used to categorise complaints
(Source Ahpra Annual Report 2023 Supplementary Table N1)

Behaviour	Informed consent
Billing	Medico-legal conduct
Boundary violation	Monitoring and compliance action
Breach of non-offence provision in the National Law	Offence against other law
Clinical care	Offence by student
Communication	Other
Confidentiality	Pharmacy/medication
Conflict of interest	Registration action
Discrimination	Research/teaching/assessment
Documentation	Response to adverse event
Health impairment	Statutory offence – National Law
Infection/hygiene	Teamwork/supervision

- We find inconsistencies in the numbers used for categorisations of notifications for 2023 (see Table 4 below) between the Ahpra Annual Report Supplementary Tables N1 and the CRIS document, with data removed in the CRIS document but fully categorised in the Annual Report Supplementary Table.
- If comparisons are to be made over time, consistency in the practices of notifications staff and training are important to the categorisation of notifications and their recording. Several reviews of Ahpra show evidence of inconsistencies in Ahpra information systems and processes:

  > 'Methods of recording investigation information are inconsistent, and there are no formal minimum requirements surrounding information to be recorded. This has the potential to impact the efficiency and integrity of investigations.' (KPMG Final Report[20], Ahpra, Review of notification systems and processes, Dec 2015, p.26)

  > An 'external audit … found inconsistencies in complaints processes and practices across the AHPRA state offices. The audit identified the need for stronger governance, and better process and technology, as well as the need for an overarching internal complaint framework with clearly defined accountabilities and improved reporting… It is also planning training and greater support for frontline AHPRA registrations and notifications staff to empower and enable them to more successfully deal with simple concerns early and directly.'(Final Report, Review of interface between AHPRA and NHPOPC[21], Lamb, 26 March 2019, p.3)

- Several independent reviews have found that Ahpra falls short in a range of areas including:

  > 'leadership capability, workplace structures, workplace practices, notifications staff training, administrative complaints handling, and staff stress, workload and burnout, inadequate resourcing, poor processes, poor induction, high turnover, poor and/or unfair recruitment practices, poor performance management or inappropriate KPI's leading to stress and strains on existing team members and helping to perpetuate uncivil behaviours.' (Building a safe and inclusive culture within Ahpra, Consolidated National Report and Recommendations[22])

- The above issues raise concerns about the legitimacy of arguments using notifications data to declare 'impairment' and to drive policy. Given the inherent errors and inconsistencies in Ahpra processes that have been raised in a number of reviews, and the lack of validity and reliability surrounding unsubstantiated complaints data, it is clear that neither of these uses is valid.

2. Biased reporting of notifications numbers

- Alongside concerns over the validity and reliability of notifications data, in this section we identify the ways in which the notifications data have been used in the CRIS document and illustrate the bias in the use of notifications numbers.

2.1. Unknown subgroup differences in notifications in under 70s

- The CRIS document does not provide a breakdown by age grouping of the number of complaints for medical practitioners under 70. In 2023, there were 18 times the number of doctors under 70 as there were doctors over 70.

Table 2. Number of medical practitioners over and under 70 in 2023

Age	**No of registered doctors** (excl. non-practising registration)
< 70	125,391
≥70	6,975

- Why might this bias the results? The number of doctors under 70 includes a very broad age range of doctors extending from those in their 20s to those in their late 60s. It includes doctors working in a range of contexts and in various stages of their career. As an example, there were 17,135 registered doctors (excl. non-practising registration) under the age of 30 in 2023 (Medical Board Report Registrant Data Table June 2023[23]). This group is 2.5 times the size of the late career cohort. Doctors who are starting their careers, in training, and undertaking internships are more likely to be employed in hospitals, for example. Complaints to Ahpra may be less likely for these groups because complaints can be directed to hospitals themselves or the concern might focus on the service rather than the individual. The HCCC[4] (2023) reports that around 40% of complaints are about health organisations including hospitals.
- It is reasonable to assume that there are differences in notification rates across subgroups within the under 70 cohort. Subgroups with low numbers of complaints may dilute the overall aggregate notification rate and increase the difference between the under 70 and over 70 groups. In other words, the rates of notification in the under 70 group may be reduced because the group contains large age subgroups that may be less likely to have a complaint directed to Ahpra. There may also be subgroups that have higher notifications than the average and are closer to that of the over 70 group. Comparison of a smaller cohort (6,975) with a much larger aggregate cohort (125,391) masks any subgroup differences in the larger cohort.

2.2. Notification numbers

- The CRIS document provides the number of complaints for doctors over 70 but does not provide the number of complaints for doctors under 70. In order to estimate this, we use the N1 supplementary table (2023) to identify the total number of notifications (5,615) and deduct the number for doctors ≥70 yrs (485). This leaves approximately 5,130 notifications for doctors under 70 (Table 3).
- The proposal makes a number of statements about notification numbers that are inaccurate. On page 21 of the proposal, the claim is made: **'**Generally, older doctors are the subject of more notifications (complaints) compared with younger doctors.' The data show that there were not more complaints made about doctors over 70. More complaints were made about doctors under 70. Of the total number of notifications in 2023, 91.4% were for doctors under 70. The number of complaints for doctors under 70 was more than 10 times the number of complaints for doctors over 70.

Table 3. Number of notifications for doctors Under 70 and Over 70 (Ahpra data)

	No. notifications[1]	% of total notifications
≥ 70	485	8.6%
< 70	5130 [2]	91.4%
Total	5615 [3]	100%

[1] The MBA Proposal does not provide source data nor the no. of notifications for doctors under 70 used in their calculations.

[2] Estimate is based on total no. of notifications (Ahpra Annual Report 2023) less the number of notifications for doctors over 70 as reported in the MBA CRIS document. Notification numbers by age are not publicly available. Annual Report Supplementary tables do not provide this.

[3] Total no. of notifications to Ahpra, Ahpra Annual Report

- Additionally, there is no information on the number of doctors within each group who had a notification. The CRIS document reports rates of notification for issue categories per 1,000 but not frequencies. Table 4 below reports the number of notifications per issue category as per the Ahpra Annual Report 2023 Supplementary Table N1 alongside the estimated number of notifications for the under 70 and late career groups. The estimates are based on Table 1 in the CRIS document which provides rates per 1000 doctors for each category.

Table 4. No. of notifications by issue and by age group 2023

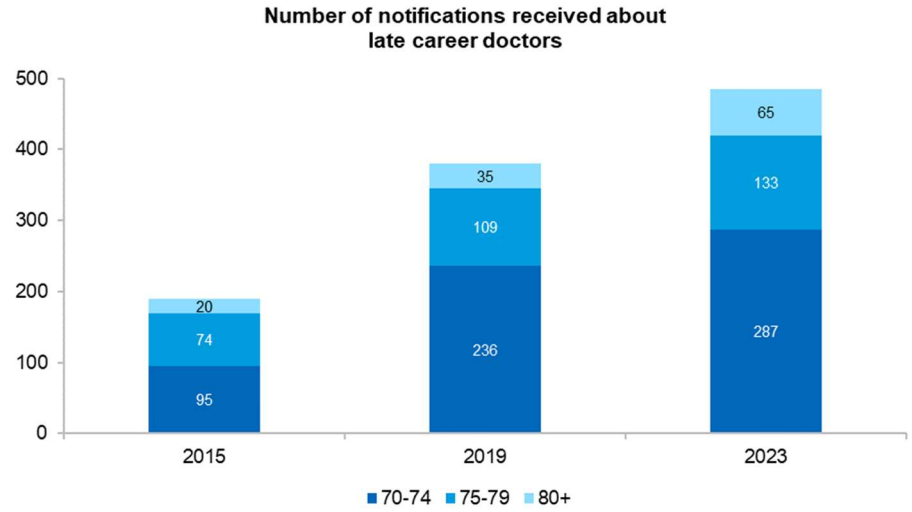
Notifications Issue category	No. of notifications (Source: Ahpra Annual Report Supp. Tables)	Est. No. <70	Est. No. ≥70	Adjusted/ missing
Behaviour	190	153	15	22
Billing	133	110	4	19
Boundary violation	153	109	9	35
Breach of non-offence provision in the National Law	68	38	4	26
Clinical care	2,428	1,996	169	263
Communication	841	589	79	173
Confidentiality	91	81	4	6
Conflict of interest	11	9	0	2
Discrimination	14	10	2	2
Documentation	336	245	35	56
Health impairment	122	79	18	25
Infection/hygiene	32	20	4	8
Informed consent	122	85	7	30
Medico-legal conduct	18	9	2	7
Offence against other law	119	82	4	33
Offence by student	1			
Other	158	122	12	24
Pharmacy/medication	727	582	85	60
Research/teaching/assessment	1			
Response to adverse event	21	19	1	1
Statutory offence – National Law	4	4	0	0
Teamwork/supervision	25	13	2	10
Subtotal		**4,355**	**456**	**802**
Adjusted: removed in CRIS because 'reason for the notification is not recorded'		451	29	(adjusted) 480
Total	**5,615**	**4,806**	**485**	(missing) **322**

- Adjustments to the numbers of category notifications are reported in the CRIS document:
  - 'Where the reason for the notification is not recorded in the Ahpra classification data, these notifications have been removed from the table.'
- This raises again the issue of consistency and accuracy in the recording of notifications data by Ahpra. 9.4% (451) of notifications for the under 70 group were removed, 6% (29) of notifications for the late career group were removed. A further 322 notifications were missing from the total of 5615 (as reported in the Ahpra Annual Report 2023). It is unclear a) to what extent the adjustments and missing data are proportioned across the two groups, b) to which categories they apply, and c) to what extent they alter the incidence rates as reported in Table 1 on page 24 of the MBA CRIS document.
- It is noted that there were only 18 notifications for *health impairment* for doctors aged ≥70, compared with 79 in the under 70 group.

2.3. Bias in reporting an increase in complaints

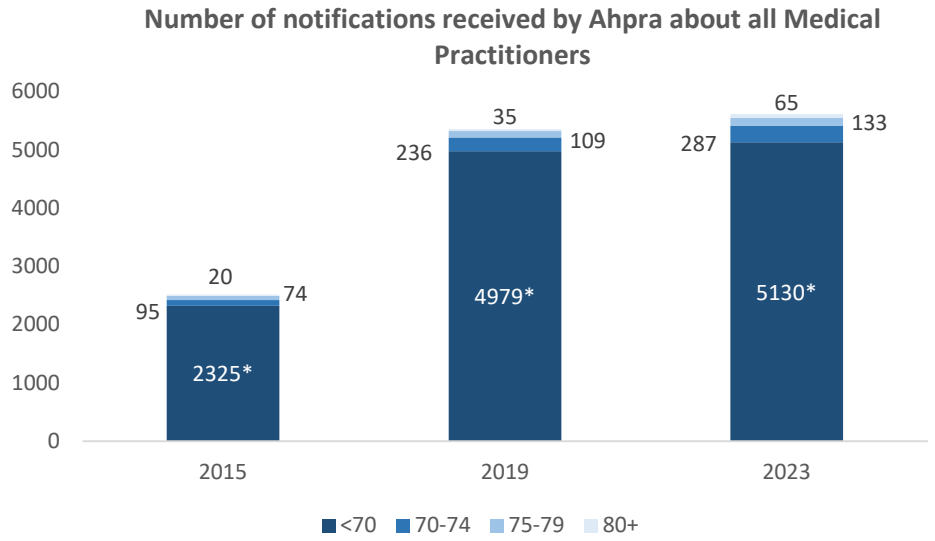
- In Figure 1 we reproduce the figure from the CRIS document (p.22) which is used to argue that there has been an increase in complaints about doctors over 70 from 2015 to 2023. The chart is misleading in the absence of comparative data about the under 70 group and implies that there has only been an increase for late career doctors.

Figure 1. Figure 7 reproduced from page 22 of the MBA Proposal Document



- Data from Ahpra annual reports for the same years shows that a rise in notification numbers for doctors under 70 has also taken place.
- When the complaints for doctors under 70 are added to the chart above (see Figure 2), it can be seen that the complaints for doctors under 70 more than doubled (2.14 times) from 2015 to 2019, an increase of 114%. For the same period, there was a 101% increase for doctors over 70. The increase for doctors under 70 was greater.

Figure 2. Number of notifications for all medical practitioners



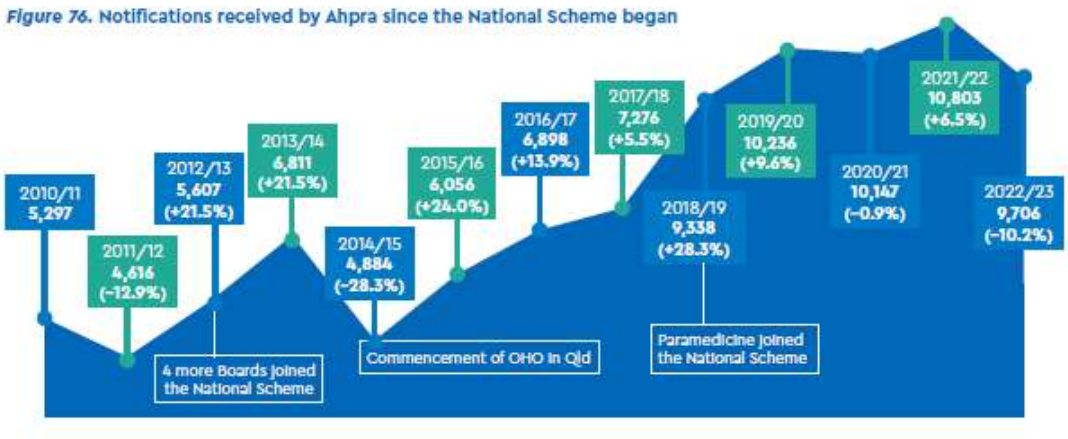
*Note: The MBA CRIS does not provide notification numbers for doctors under 70, only for over 70. Estimates have been calculated using the total number of notifications to Ahpra in the Ahpra Annual Reports and Supplementary Tables (2015, 2019, 2023). Numbers of complaints for doctors under 70 have been estimated by deducting the number of notifications for doctors over 70 (MBA proposal document) from the total number of notifications in these sources. There were 2514 notifications for 2015, 5359 notifications for 2019 and 5616 notifications for 2023.

- The above charts, Figure 1 and Figure 2, show that displaying complaints numbers for doctors over 70 without reference to total notifications and to the number of notifications for doctors under 70 leads to a biased portrayal of complaints in the late career group.

2.4. Rises in complaints across all health practitioners and about Ahpra/Health Boards

- Ahpra annual data show that these increases are not specific to late career doctors, as there are increases for all doctors and all health practitioners. As Ahpra data (Figure 76 below) shows, there was a 91.2% rise in complaints across all health practitioners from 2014/15 to 2018/19 and a rise of 121% to the peak in 2021/22.

Figure 3. Figure 76 reproduced from Ahpra Annual Report 2023



- These increases raise questions such as what contextual, institutional or societal factors are at play in increasing complaint rates? Age or competency of practitioner do not appear to be the main drivers of these increases as they apply across all doctors and health practitioners. How do these rates of complaint compare to other professionals? Does increased advertising of complaints processes play a role? Has modern society become a culture of complaint? What role has the COVID era and concomitant health care issues and mandates (e.g., mask wearing, access to medications) played in complaints? What roles do social media, 'Dr Google', and levels of health literacy play?
- The HCCC Annual Report for 2023[4] indicates a 101.1% growth in the number of complaints to the HPCA in NSW over the decade from 2012-13 to 2022-23. They report that 'this is consistent with the national and international picture, and research indicates that the driving factors are:
  - — Population growth and ageing.
  - — New and emerging health concerns.
  - — Expansion on the types of health services and alternative therapies.
  - — Greater consumer expectations and access to medical information through the internet and social media.
  - — Awareness of complaints bodies.
- Complaints have also risen significantly about how notifications are handled by Ahpra and/or a board (for all health practitioners). From 2016 to 2023 complaints to the National Health Practitioner Ombudsman (NHPO) in relation to how Ahpra and/or a board handled a notification increased by over 330% (see Table 5). The number of complaints in 2023 about Ahpra and/or a board was 4.34 times the number of complaints in 2016. Data on specific complaints about the Medical Board could only be found in the NHPOC report for 2016 – 72 complaints.

Table 5. Complaints about how Ahpra/relevant board 'handled a notification' to NHPO (excluding complaints about registration)

	2016[1]	2017[2]	2018[2]	2019[2]	2020[2]	2021[2]	2022[2]	2023[2]
No of complaints about how Ahpra/relevant Board handled a notification	99	208	288	305	351	343	309	430

[1] National Health Practitioner Ombudsman Annual Report 2015-16
[2] National Health Practitioner Ombudsman Annual Report 2022-23

- In summary, notifications (complaints) about health practitioners have been increasing over the last decade. The Ahpra Medical Board CRIS document provides a misleading argument by only providing data on the rise in numbers of complaints for late career doctors and by not providing the context of the rises, i.e., increasing complaints across all doctors, all health practitioners, and, indeed, for Ahpra and the boards themselves. The HCCC report acknowledges that a number of factors play a role, including consumer expectations and access to medical information through the internet and social media, and awareness of complaints bodies.

3. Failure to distinguish between the number of complaints and the number of doctors with a complaint.

- The MBA CRIS document provides data on notifications but does not provide information on the number of doctors with notifications in the over 70 group nor for doctors in the under 70.
- Knowing the number of doctors with notifications is important because a doctor may have more than one notification. Research has shown that some doctors have more notifications than other doctors. Additionally, notifications may be categorised as involving more than one issue. (e.g., Bismarck et al.)
- The national data (Ahpra +OHO + HPCA) and Ahpra data alone show that there can be multiple notifications for doctors with a notification. National data show an average of 1.28 notifications per doctor with a notification, while Ahpra data alone shows a rate of 1.25 (see Table below) for 2023. This rate can vary. Bismarck reports a rate of 1.98, for example.

Table 6. Summary of medical practitioners with notifications in 2023
(Source: Ahpra Annual Report 2023)

	National	Ahpra
No of notifications	9,938	5,615
No of doctors with notifications	7,761	4,494
Average no. of notifications per doctor with notification	1.28	1.25
No of registered doctors	136,742	
% of registered doctors with a notification in 2023	5.68%	

1 Ahpra, Office of the Health Ombudsman (OHO, Qld), Health Professionals Councils Authority (HPCA, NSW)

- Both the number of notifications and the rate of notifications per 1,000 doctors in the CRIS document overstate the actual number of doctors with a complaint.

- While the MBA CRIS document describes the rate of notifications per 1000, it does not provide data on the number of doctors over and under 70 who are with one or more complaints.
- According to Ahpra data (supplementary Table N1 Ahpra Annual Report 2023) there was a total of 5,615 notifications against 4,494 medical practitioners in 2023. With 485 notifications in the over 70 group, this leaves 5,130 notifications for the under 70 group (see Table 7).

Table 7: Estimate of the number of medical practitioners over and under 70 with notifications to Ahpra (1.25 notifications per medical practitioner with a notification[1])

	Medical Practitioners < 70		Medical Practitioners ≥ 70		Total	
	No.	**%**	**No.**	**%**	**No.** [1]	**%**
No. of notifications to Ahpra 2023	5130 [2]	91.4%	485 [3]	8.6%	5615	100%
[4] **Estimated no. of medical practitioners with notifications to Ahpra 2023**	4104	91.4%	388	8.6%	4494	100%

[1] Ahpra Annual Report 2023
[2] Estimated by calculating difference between the total number of notifications in the Ahpra Annual Report 2023 and the number of notifications for doctors over 70 in the MBA Ahpra CRIS document.
[3] CRIS document
[4] **Applying 1.25 rate**

- For doctors under 70, using the Ahpra average rate of 1.25 notifications per doctor with a notification, it is estimated that the 5130 notifications apply to approximately 4104 doctors under 70.
- In absolute terms, approx. 8.6% of notifications to Ahpra were for doctors over 70, while the vast majority (91.4%) were for doctors under 70. There were over ten times the number of notifications and doctors with notifications in the under 70 group than in the over 70 group.
- For doctors over 70, using the Ahpra average rate of 1.25 notifications per doctor with a notification, it is estimated that the 485 notifications reported in the document apply to approximately 388 doctors over 70.
- As information on the actual number of doctors with notifications under and over 70 does not appear in the CRIS document, the above is our best estimate of the maximum number of doctors.
- It is possible that a number of doctors in both groups are the focus of a higher-than-average number of notifications as described above. In which case, a smaller number of doctors have complaints. Bismark, Spittal & Studdert [24] (not referenced in the CRIS) report that, while there was an average of 1.98 notifications per doctor, there were "frequent flyers" (up to >10 notifications):
  - 15% of all doctors named in complaints comprised 49% of all complaints
  - 4 % of all doctors named in complaints comprised 25% of complaints
  - 3% of doctors overall comprised 49% of all complaints.
  - 1% of doctors overall comprised 25% of complaints.

- The sample for their study comprised mainly under 65s. The more complaints the greater likelihood of an additional complaint(s) in the future. A focus on doctors of any age with multiple complaints would be a more productive approach than the ageist approach of assessing all doctors over 70.
- Given the above findings, both the number of notifications (485) reported by Ahpra and our estimate (in the absence of publicly available data) of doctors with notifications (388) overstate the number of doctors over 70 with notifications.

4. Regulatory Action Rates

- As mentioned, analysis of notifications data is problematic because it is based on categorisation and recording of complaints that are unsubstantiated. The vast majority are discontinued. Notifications that lead to regulatory action provide information on complaints which have been assessed as having substance.
- The MBA CRIS document indicates that there were 485 complaints with doctors over 70 in 2023. Of these complaints, 23.2% or 113 complaints led to regulatory action.

Table 8: Ahpra notifications leading to regulatory action for doctors over 70 (2023)

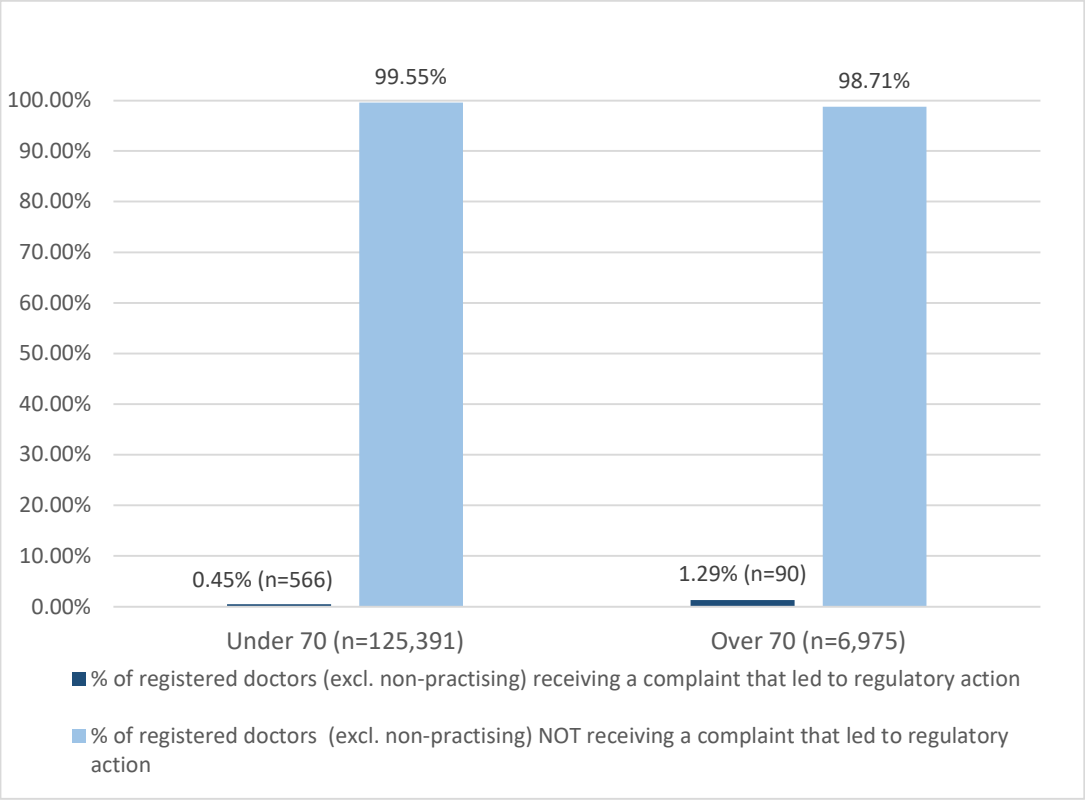
Number of complaints for doctors over 70[1]	485
% of complaints leading to regulatory action[1]	23.2%
Number of complaints leading to regulatory action	113
Estimated no. of doctors over 70 with complaint leading to regulatory action (1.25 complaints per doctor with a complaint)	90
Estimated % of all registered doctors over 70 (excl. those with non-practising) with a notification leading to regulatory action.	1.29% of 6,975 doctors

[1] MBA Ahpra CRIS document

- There were approx. 5130 complaints (estimated as above) with doctors under 70 in 2023. Of these complaints 13.8% or 708 led to regulatory action.
- Of the notifications leading to a regulatory action (n=820), 86.3% were for doctors under 70, 13.7% were for doctors over 70.
- 76.8% of complaints with doctors over 70 did not lead to regulatory action. Regulatory action for the 23.2% of notifications included caution, accept undertaking and impose conditions.
- Fines, reprimands, and suspension of registration, more stringent actions, did not occur for over 70s although they did for under70s.
- There is no data in the CRIS document on the numbers of doctors who were the subject of regulatory action, only notifications. Using the adjustment rate of 1.25 notifications per doctor with a notification, **we estimate 90 doctors over 70 were the focus of regulatory action with an estimated 58 having conditions imposed.**
- Only 1.29% of all registered doctors over 70 (excl. non-practising registration) received a notification with Ahpra that led to a regulatory action in 2023. That is, nearly 99% of doctors over 70 did not receive a notification with Ahpra leading to a regulatory action.

- Given the same rate of 1.25 notifications per doctor with a notification and an estimated 5130 complaints in the under 70 group, it is estimated that there were 566 doctors with 708 complaints leading to regulatory action in the under 70 group.
- **The number of doctors with complaints leading to regulatory action in the under 70 group was six times the number in the over 70 group.**
- The graph below shows that the absolute difference of 0.84% between the groups in notifications leading to regulatory action.

Figure 9: Estimated percentage of all registered doctors (excl. non-practising registration) under 70 and over 70 receiving and not receiving a complaint (with Ahpra) leading to regulatory action.



5. Health Impairment

- The Medical Board CRIS document makes a number of statements about the impairment status of doctors over 70. One of the categories used in assessing notifications by Ahpra and the HPCA is 'health impairment'. While no definition is provided, the National Law defines impairment as: 'physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect' their capacity to practise. For students, the impairment would, or be likely to, affect their capacity to undertake clinical training.'
- In 2023, Ahpra received 5,615 notifications (Ahpra Annual Report). **Of these, 122 or 2.17% were categorised as health impairment**. **Data from the HPCA (NSW) similarly shows a low percentage - 2.05%.**
- The MBA CRIS (Table 1) identifies the rates per 1000 doctors and these are reproduced in the following table. The number of notifications for doctors over and under 70 has been estimated using registration data (Ahpra Annual Report Tables, MBA CRIS) and the rates supplied in the CRIS table.

Table 10. Health Impairment Complaints

	Group	Rate per 1,000 doctors (excl. non practising) with health impairment notification (MBA Ahpra CRIS)	No of registered doctors (excl. non-practising) (Ahpra Annual Report supplementary tables and CRIS)	Estimated no. of health impairment complaints	No. of doctors with a health impairment complaint	No. of health impairment complaints leading to regulatory action
2023	< 70	0.63[1]	125,391	79[2]	Not provided	Not provided
	≥ 70	2.5806	6,975	18	Not provided	Not provided
2019	< 70	1.1730	109,970	129	Not provided	Not provided
	≥ 70	1.7710	6,211	11	Not provided	Not provided
2015	< 70	1.0709	95,249	102	Not provided	Not provided
	≥ 70	1.5322	5,221	8	Not provided	Not provided

Notes:

[1] If we compare the preceding two data points, 2015 and 2019, with 2023, the rates are somewhat different for 2023, suggesting that the complaints data is anomalous for 2023. A higher rate is found in 2015 and 2019 for doctors under 70 than for 2023. The rate then nearly halves for 2023. There is no explanation for the anomaly. Did categorisation of health impairment change for 2023?

[2] Additionally, the total number of health impairment complaints in 2023 was 122 (See Table 2 in this submission). 25 notifications have not been included, either through adjustment for the CRIS document or missing from the reported data (See Table 2).

- The CRIS document does not indicate the number of doctors with a health impairment complaint nor does it indicate whether any of the health impairment complaints led to regulatory action for doctors over 70 years or under 70 years.
- There is a very low percentage of complaints that are categorised as health impairment. Using the MBA proposal Table 1 rates per 1000 doctors, **it is estimated that, at most, 18 doctors**

(using 1 notification per doctor) over 70 had a complaint categorised as health impairment with Ahpra. No information is presented or publicly available on whether any of these complaints resulted in regulatory action.

- **In absolute terms, for 2015 and 2019, over 10 times as many doctors under 70 had health impairment complaints than doctors over 70. For 2023, it is 4 times. This change is anomalous and suggests something other than age is a factor.**
- We note that health impairment notifications have been declining as a percentage of the number of overall notifications since 2015. This decline does not support the argument that health impairment notifications have been an increasing issue.

Table 11: Health Impairment Complaints as a Percentage of Total Notifications
(Source: AHPRA Annual Report Supplementary Tables)

Year		No of health impairment notifications	Total no. of categorised notifications	% of categorised notifications
2014/2015	Ahpra	187	2,514	7.44%
2018/2019	Ahpra	173	5,359	3.22%
2022/2023	Ahpra	122	5,615	2.17%

- We also note the difference between the 2023 data and the data used by Thomas et al. (Table 12). The definition of impairment above includes substance misuse and mental illness, along with physical and mental impairment. Thomas et al. separated these areas of impairment in their recoding of data. No mention of mental illness and substance misuse, which were higher for the younger group in Thomas et al., is included in the CRIS document.

Table 12. Comparison of 'health impairment' notifications in Thomas et al. (2018) and MBA Ahpra CRIS (2024)

	Thomas et al. 2018 % of notifications (4 year data: 2010-2014)		MBA Ahpra CRIS (2024) % of notifications (1 year data: 2023)	
	36-60 yrs	**>65yrs**	**<70**	**≥70**
Mental illness and substance misuse	3.4% (n=383)	1.5% (n=24)	Not provided	Not provided
Physical illness/Cognitive decline	0.4% (n=45)	4.5% (n=72)	Not provided	Not provided
Total health concerns/health impairment	3.8% (n= 428)	6.0% (n=96)	[1]1.8% (n=79)	3.9% (n=18)

[1] Data appears anomalous for <70-year-olds for 2023 compared to previous data years. The rate is much lower than would be expected from previous years. See Table 10 notes.

- While it is difficult to estimate the percentage for under 70s given the lack of publicly available data, the table above illustrates that there has been a decline in health impairment notifications as a percentage of all notifications for the late career group. The higher rate of mental illness and substance misuse notifications in the younger cohort reported in Thomas et al. is not commented upon in the CRIS document.

6. Use of relative risks without reference to absolute risks and absolute numbers

6.1. Relative risk versus absolute risk problem

- Reporting relative rates of unsubstantiated complaints without reference to absolute numbers and outcomes serves to grossly overstate issues. Of what meaning is it to know that unsubstantiated complaints for one group are 1.7 times that of another group, if we know nothing of the veracity of the complaints, or the actual outcome of the complaints?
- The CRIS document provides tables of incident (risk) rates and refers to incidence rate (risk) ratios, but nowhere is the reader informed of the absolute numbers of doctors that the issues apply to.
- This is problematic because *one cannot be interpreted without the other* (Noordzij *et al*., 2017, p.ii13)[25]. 'Relative risks have the appealing feature of summarizing two numbers (the risk in one group and the risk in the other) into one. However, this feature also represents their major weakness, that the underlying absolute risks are concealed and readers tend to overestimate the effect when it is presented in relative terms. In many situations, the absolute risk gives a better representation of the actual situation.'
- The MBA relies on the use of relative ratios of unsubstantiated complaints to argue that older doctors are impaired. The medical profession is aware of the problem that arises when trial results are reported as relative ratios without the absolute and base numbers of individuals treated. Absolute numbers are natural frequencies[26].
- As an example, say the risk of a disease is 1 in 100 in non-smokers but increases to 2 in 100 in smokers. In relative terms, there is a 100% relative increase in that disease in smokers. Another way of saying this is that smokers have a 2.0 times increased risk. However, it is clear from the frequencies that the absolute difference between the groups is 1% or 1 person per 100. **It is important to know both the relative and absolute numbers to make an informed decision.**

6.2. The Thomas et al. article

- The MBA has emphasised the findings of Thomas et al.[2] both in the CRIS document and in media releases. Thomas et al. make the claim that complaints categorised as *Illness/Cognition* are 15.4 times (IRR) more likely in a late career group (over 65) than a younger group (36-60) of doctors.
- What data did the study use? Notifications were coded at the time they were received by the regulator- 'this coding does not reflect new information revealed during subsequent assessment and adjudication processes' (p.7). The data were unsubstantiated complaints that were received and had yet to be discontinued or substantiated.
- How many doctors? There were 49,313 aged 36-60 years and 7,627 doctors aged >65 across the years. Doctors aged between 60 and 65 in 2010 were excluded from the study. The number is not provided but it is estimated that approx. 6,000 doctors aged 60-65 were excluded (Ahpra Annual Report 2010-11) because they would overlap the age groupings. It is unclear how this might have impacted relative rates.
- The relative rates in the analyses used notifications per 'practitioner years' not per 1,000 doctors as in the CRIS document so the rates in the two documents cannot be compared.
- One of the assumptions was that doctors are exposed to risk of notification only when they are engaged in clinical practice. Because the authors 'did not observe' clinical practice time 'at the individual level' (i.e. there was no data available and they did not collect it), they constructed the variable 'practitioner years' by multiplying the number of years the doctor was registered during the study's four years by an average number of hours worked. The average number of

worked hours was based on several variables – sex, speciality and age - with the data taken from the 2015 Health Workforce Survey and averaged for each group. For example, all female psychiatrists aged 66 yrs (66-75 band in their appendix table) were assumed to have worked an average of 19.5 hours, while all 60-year-old female psychiatrists were assumed to work 27 hours (56-65 band in appendix table).

- Is this assumption valid? Is this an adequate representation of clinical exposure? One might assume that the number of patients seen would be a factor in clinical exposure. This was not assessed. It is assumed that, in the case of the two groups mentioned (60- and 66-year-old female psychiatrists), if both had the same number of notifications and were registered for the same duration in the study, the older group would have a higher notification rate because 'practitioner years' is based on a lower average number of working hours as per the Health Workforce Survey data. This is irrespective of whether female psychiatrists in the older group actually worked more hours than the average or saw more patients. A doctor deemed to be working 27 hours but seeing the same number of patients as a doctor deemed to be working 19.5 hours would be assumed to have a higher clinical exposure leading to a lower notification rate.
- It is important to identify the underlying assumptions of analyses and the use of estimates and constructed variables that might not be consistent with other analyses or reports or might not be clear in re-reporting of results.
- The data do not distinguish between physical illness and cognitive impairment (current categorisation of notifications using 'health impairment' does not do this either).
- Again, it must be remembered that the data was collected in 2011-2014 and is now over 10 years old, therefore referring to an earlier cohort of doctors. It refers only to unsubstantiated complaints not to those that were found to have any substance. It excluded doctors aged 60-65 and used a constructed variable 'practitioner years' to calculate notification rates.
- In absolute terms, here are some of the findings of the study:
  - 86.8% of doctors over 65 did not receive a notification.
  - 13.2% of doctors (n=1007) aged over 65 received a notification. There were 1607 notifications resulting in approx. 1.60 notifications per doctor with a notification.
  - 15.8% or doctors (n=7,791) aged 36-60 received a notification. There were 11,271 notifications resulting in 1.45 notifications per doctor with a notification.
- The table below shows that, overall, there was a higher percentage (15.8%) of younger doctors with notifications than older doctors (13.8%) (sig. at p<.001, note: not reported in paper), although the paper finds varying differences by specialty.

Table 13. Comparison of doctors 36-60ys and >65 yrs in Thomas et al. 2018

	Age group	
	36-60yrs	**>65yrs**
No. of doctors in study	49,313	7,627
No. of doctors receiving a notification	7,791	1,007
% of doctors receiving a notification	15.8%	13.2%
% of doctors not receiving a notification	84.2%	86.8%
No. of notifications	11,271	1,607
Average number of notifications per doctor receiving a notification.	1.45	1.60
% of all notifications leading to regulatory action	8.5%	

- Physical illness/cognitive decline was the focus of 4.5% of the 1,607 notifications for the older age group. There were 72 notifications for physical illness/cognitive decline for the group of 7,627 doctors over 65. If 72 notifications refer to 72 unique doctors, then 0.98% of doctors over 65 received a complaint related to physical illness/cognitive decline.
- If we compare the IRR values reported in Thomas et al. with absolute numbers, we find that:
  - The IRR value for notifications regarding *physical illness/cognitive decline* for older vs younger groups, based on 'practitioner years', is reported as 15.54. In absolute numbers, this notification applied to **a maximum of 72 doctors over the age of 65** and **a maximum of 45 doctors aged 36-60**, if we assume 1 notification = 1 doctor. The number for older doctors is 1.6 times the number for the younger group.
  - The IRR value for notifications regarding *mental illness and substance misuse*, based on 'practitioner years', is reported as 0.58 (older/younger) or 1.7 (younger/older). In absolute numbers, this notification applied to a maximum of **24 doctors over the age of 65** and a maximum of **383 doctors (or less) aged 36-60**. The number for younger doctors is 16 times (15.96) the number for the younger group.

Table 14. Percentage and numbers of doctors with complaints re *physical illness/cognitive decline* and *mental illness and substance misuse* in Thomas et al. 2018

Age	Total no. of doctors	Total no. of notifications	% of Notifications: *Physical Illness/ Cognitive decline*	[1]Est. no. of doctors *Physical Illness/ Cognitive decline*	% of Notification: *Mental Illness and Substance Misuse*	Est. no. of doctors *Mental Illness and Substance Misuse*
36-60	49,313	11,271	0.40%	45	3.40%	383
>65	7,627	1,607	4.50%	72	1.50%	24

1. Estimated using 1 notification = 1 doctor as maximum number of doctors, given the possibility of more than one notification across the years of the study.

- It can be seen from the above that the use of relative ratios on small numbers in the absence of absolute frequencies can overstate issues. Given the much larger number of doctors in the younger group who have notifications related to mental illness and substance abuse, and if public safety is the primary concern of the regulator, why not introduce mandatory drug testing for younger doctors? Or psychiatric assessments for this group?
- It is important to note that these analyses refer to notifications or unsubstantiated complaints. Of the total 12,878 notifications, 8.5% or 1,095 notifications led to regulatory action. 91.5% of notifications did not lead to regulatory action. The paper does not indicate the percentage nor number per doctor group (>65, 36-60) nor the types of notification that led to regulatory action in either group.

7. International Medical Graduates (IMGs) have a higher notification risk.

The CRIS document does not acknowledge the increased risk of notifications concerning IMGs even though four of the MBA CRIS references that are used to show 'impairment' in older doctors, actually report an increased notification risk for IMGs. We do not suggest targeting IMGs but wonder why these results have been omitted in the CRIS document which only focuses on age as a problem.

In the CRIS document:

- *Peisah[27] 2007* [Aus]: 53% of 41 'impaired' doctors were IMGs.
- *Kataria[6] 2014* [UK]: Using an ACE-R (Addenbrook Cognitive Examination-Revised) score ≤ 88 as a cutoff, 21 out of 22 of the practitioners were IMGs.
- *Khaliq[28] 2005* [USA]: IMGs were found at increased risk of notifications on univariate but not multivariate analysis.
- *Donaldson[29]* 2014 [UK] found that IMGs were twice as likely to have notifications.

In addition:

7.1. *Elkin Spittal Studdert[30] 2012* [Aus]: IMGs from 7 countries (out of 20) were at increased risk of notifications compared with Australian trained graduates.

8. Failure to properly scrutinise references used to argue for impairment in late career doctors.

- The CRIS document fails to properly scrutinise references used to argue for impairment in late career doctors and has omitted studies that support a different perspective. Indeed, there are many examples of misquoting results from the references used in the document in order to further a stereotyped argument about late career doctors. This is very concerning and reflects a failure of the author/s of the document to understand the papers they have summarised. A number are dated (over 20 years old) and/or refer to small numbers. Many are written from a regulator's perspective[6 31]. Some authors are on medical boards or medical indemnity insurers with a potential bias.
- One example is the Kataria[6] et al. study on cognitive function in 109 practitioners (doctors & dentists) over the age of 45 years. The reporting of the results in the CRIS document omits key information on the characteristics of the doctors; that 64% of those with a low score were below age 60 and that a majority were international medical graduates (IMGs).

  CRIS document states:

  - Twenty-two were found to have an ACE-R (Addenbrooke Cognitive Examination - Revised) score ≤ 88, indicating a potential cognitive issue. On further assessment, 14 of these 22 practitioners (65%) were found to have cognitive impairment.

  Omitted from the CRIS document:

  - Of those doctors with ACE-R score ≤88, 50% were under 60 years in age and 14% were aged 45-49. Of the 22 practitioners with a score ≤88, 21 were IMGs.

- In Australia and elsewhere, a number of reports and commentaries have shown a heavy reliance on a small number of articles purporting to find cognitive impairment with age in doctors. For example, along with the MBA Aphra CRIS document, both Draper[32], in an editorial for the Medical Journal of Australia, and the Medical Board Expert Advisory Report on Revalidation[33] cite the review conducted by Choudhry et al.[34]. This paper is of inferior quality in terms of

assumptions, data selection, method of analysis, and deductions. While it is claimed that the article shows cognitive impairment with age in doctors, in fact, the meta-analysis did not address cognitive impairment at all. It is now over 20 years old, based on US data and does not reflect current medical practice.

- Moore[35] provides a comprehensive rebuttal of the Choudhry review and shows that a number of studies included in the paper lacked any statistical analysis, confounded issues such as competency with cognition, and aggregated age groups in ways that couldn't lead to the conclusions being made:

  "Choudhry et al.'s oft-cited meta-analysis of sixty-two studies evaluated various quality of care measures such as compliance with evidence-based guidelines and medical knowledge. The study, however, did not address cognitive impairment. The researchers concluded that thirty-two of the studies (52 percent) showed an inverse relationship between "performance" and age or years in practice. However, many of the studies with a negative age association grouped their cohorts in brackets such as ">10 years" or ">20 years in practice," which would include physicians in their forties and fifties, respectively, or used an age between forty and fifty to divide physicians into two large groups. The age range of these cohort groups is too wide to justify screening for a particular narrow subset. Furthermore, as the article points out, several of the included studies did not present statistical tests." (pp. 115-116).

- Moore finds that many studies cited as evidence for cognitive testing conceptually conflate cognitive impairment with lack of competency, and fail to age stratify and distinguish between mid- and late-career doctors, and concludes that "singling out all older physicians for cognitive testing is empirically unjustified and legally prohibited" (in the US). "Furthermore, there are other means to reliably monitor and identify physicians, both older and younger, who pose risk to patients."

- In relation to the MMSE, the CRIS document states, "A study of older people with greater education showed a MMSE score of less than 28 was more sensitive in detecting impairment than the standard threshold of 23 or less". The reference by O'Bryant [11], both in the conclusion and text, in fact uses a cutoff score of 27 meaning 26 or lower - "This cutoff has an optimal balance between sensitivity and specificity". No medical doctor MMSE norms are available. Using a non-validated cut off score to screen doctors is highly problematic.

- It is clear from recent research and theory that assertions that normal ageing necessarily entails cognitive decline are based on outdated models of cognitive ageing. Such generalisations are sufficiently non-specific to be unhelpful in determining practical outcomes.

- Recent advances in the neuro-cognitive sciences show that maintenance of many cognitive functions continues into advanced age. Cognitive aging is a highly heterogeneous clinical phenomenon with equally diverse underlying biology [36]. A number of researchers are calling for a re-evaluation of deficit models of cognitive ageing that view decline as an inevitable consequence of ageing.

- It is beyond the scope of this submission to provide a detailed review and analysis of the current evidence for cognitive abilities across the adult lifespan, however some examples illustrate the progress being made.

  - Harrington et al.[37] report that age (in 60- to 85-year-old Australians) is not associated with a decline in verbal or working memory and that previous research has overestimated the level of decline by not controlling for underlying pathological processes (e.g., onset of Alzheimer's Disease). Moreover, these authors suggest that the validity of some neuropsychological measures might be called in to question. For example, common processing speed tests (a measure of fluid intelligence) involve speeded motor responses

and may therefore confound measurement of motor response with processing speed. They report that research using other methods such as Inspection Time tests show no age declines.

- Other research suggests that potentially unique brain networks underpin the same cognitive skill differently across age periods. For example, 'hippocampal-based networks better predict memory functioning in younger adults, whereas frontostriatal networks better predict memory functioning in older adults'[38].

- Many accounts of age-related differences are based on cross-sectional analyses. There is now recognition that such analyses fail to capture individual trajectories that are often more positive than group statistics reveal and that there is high intraindividual variability across time. For example, longitudinal research shows stability as well as improvement in processing speed and executive functioning in many typically ageing older people[39]. Research also identifies 'superagers' who show superior cognitive skills into later life and the role of 'cognitive reserve', often linked to educational and occupational attainment, in preserving abilities[40].
- The growing evidence suggests that there is no stable basis for arguing that cognition necessarily declines with chronological age and that, in measuring cognitive resources, one must be clear about the abilities being measured, how they are measured, the people they're being measured in, and what their relevance is to practice. Many researchers are adopting the premise that cognitive ageing is biologically-driven rather than chronologically-driven and that explanations and measurements of cognitive changes are under-developed at this time[36]. Rather than promulgating a deficit model of cognitive resources, there is growing research on how cognitive resources are maintained and enhanced with appropriate lifestyle and health choices across the lifespan.

9. Institutional ageism in regard to late career doctors.

9.1. Ageism

The World Health Organisation's Global Report on Ageism [7] notes that ''ageism is prevalent, deeply ingrained and more socially accepted than other forms of bias" and that "globally, one in two people are ageist against older people". Age discrimination commissioner Kay Patterson[8] calls ageism "the least understood form of discriminatory prejudice" and "more pervasive and socially accepted than sexism and racism".

9.2. Age-Based Stereotype Threat Impact on Cognitive Testing

Research shows that:

- 'there is clear evidence that older adults' memory and cognitive performance is negatively affected by threat from age stereotypes, and that these effects persist across gender and age groups (within later life). Moreover, we have established that vulnerability is greater when threat is induced by stereotypes rather than by facts' [41]
- 'There is now more than a decade of research accumulating to show that older adults may be vulnerable to ABST when they perform memory, cognitive, or physical tasks.' [41]
- 'Aging stereotypes are found to be strong predictors of health and illness outcomes in later life, and are associated with performance in specific areas, mainly in cognitive and physical domains.[42]
- 'In clinical settings, older adults often feel that their physicians have negative expectations about their abilities because of their age. These feelings of age-based stereotype threat

can increase older adults' subjective cognitive complaints and impair their performance on mental status examinations'.[43]

- 'aging stereotypes have actually become more negative in recent years. As a result, Gullette (2011) noted that we "are edging closer to accepting a new stereotype that cognitive function falls off in midlife" (p 193). In accepting this stereotype as truth, we may be spreading an "epidemic of fear" (Gullette, 2011; p. 199) in which the current generation of older adults is experiencing heightened concern about their own abilities as they age.[9]

- A concerning feature of the CRIS document is the level of ageism that is inherent in its portrayal of older doctors. Many of the statements around health and cognitive impairment are not borne out by current research and serve to perpetuate the stereotype of older age as synonymous with impairment. Institutional policies and practices that perpetuate stereotypical beliefs about older people constitute 'institutional ageism' [7] and, if left unchecked, drive ageist policies.

[1] Bismark MM, Spittal MJ, Studdert DM BMJ Qual Saf 2013;22:879-880. Correspondence
[2] Thomas LA, Studdert DM Spittal MJ Bismark MM. Health, performance and conduct concerns among older doctors: A retrospective cohort study of notifications received by medical regulators in Australia. J of Patient Safety and Risk Management 2018; 0 :1-9
[3] Ahpra Annual Reports, available at https://www.ahpra.gov.au/Publications/Annual-reports.aspx
[4] Health Care Complaints Commission Annual Reports, available at https://www.hccc.nsw.gov.au/publications/annual-reports
[5] Peisah and Wilhelm, The impaired aging doctor. Int Med J 2002; 32:457-9.
[6] Kataria N et al A retrospective study of cognitive function in doctors and dentists with suspected performance problems J Royal Soc. of Medicine 2014;5: 1-9
[7] World Health Organization Global Report on Ageism, 2020. https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combatting-ageism/global-report-on-ageism
[8] What's age got to do with it? Australian Human Rights Commission 2021, https://humanrights.gov.au/our-work/age-discrimination/publications
[9] Barber SJ. An Examination of Age-Based Stereotype Threat About Cognitive Decline. Perspect Psychol Sci. 2017 Jan;12(1):62-90. doi: 10.1177/1745691616656345.
[10] Lamont RA Swift HJ Abrms D A Review and Meta-analysis of Age Based Stereotype Threat: Negative Stereotypes, not facts, do the damage. Psychology and Aging 2015;30: 180-193
[11] O'Bryant SE et al Detecting dementia with the Mini-Mental State Examination in highly educated individuals. Arch Neurology 2008; 65:963-967.
[12] Ahpra Annual Reports, available at https://www.ahpra.gov.au/Publications/Annual-reports.aspx
[13] Health Care Complaints Commission Annual Reports, available at https://www.hccc.nsw.gov.au/publications/annual-reports
[14] Ahpra Annual Report 2023, https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2023.aspx
[15] HCCC 2023 Annual Report, https://www.hccc.nsw.gov.au/publications/annual-reports
[16] Ahpra Regulatory Operations Guideline: Managing-risk-to-public-safety-via-relevant-action, 2018. https://www.ahpra.gov.au/search.aspx?f.date%7Cd=d%3D2011&profile=ahpra&query=national+board+s+national+register&collection=ahpra-websites-web&f.Content+type%7Ccontent=policies
[17] The Senate Community Affairs References Committee: Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law, 2022. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AHPRA/Report
[18] Ahpra Regulatory Guide 2024, https://www.ahpra.gov.au/Publications/Corporate-publications.aspx
[19] Ahpra Annual Report 2023 Supplementary Tables, https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-2023.aspx
[20] KPMG Final Report[20], Ahpra, Review of notification systems and processes, Dec 2015, https://www.ahpra.gov.au/Publications/Corporate-publications.aspx
[21] Rae Lamb Final Report, Review of interface between AHPRA and NHPOPC, 26 March 2019.

[22] Building a safe and inclusive culture within Ahpra, Consolidated National Report and Recommendations, https://www.smh.com.au/national/hallmarks-of-distrust-ahpra-staff-fear-public-at-risk-due-to-super-toxic-culture-20230117-p5cd1q.html

[23] Medical Board Report Registrant Data Table June 2023, https://www.medicalboard.gov.au/News/Statistics.aspx

[24] Bismark MM Spittal MJ and Studdert DM. Identification of doctors at risk of recurrent complaints. A national study of healthcare complaints in Australia BMJ Qual Saf 2013;22: 532-40

[25] Noordzij *et al*., Relative risk versus absolute risk: one cannot be interpreted without the other, 2017, Nephrol Dial Transplant (2017) 32: ii13–ii18.

[26] Gigerenzer What are natural frequencies? BMJ 2011;343: d6386

[27] Peisah and Wilhelm, Physician don't heal thyself: a descriptive study of impaired older doctors. International Psychogeriatrics, 2007, 19:5, 974–984

[28] Khaliq AA et al Disciplinary action against physicians AJM 2005;118: 773-777

[29] Donaldson LJ et al Identification of performance in a national medical workforce over an 11-year period: An observational study. BMJ Qual Saf 2014; 23: 147-151

[30] Elkin K Spittal MJ Studdert DM Risk of complaints and adverse disciplinary findings against international medical graduates in Victori and Western Australia. MJA 2012;197: 448-452

[31] Peisah and Wilhelm, The impaired aging doctor. Int Med J 2002; 32:457-9.

[32] Draper, B.M. (2017), Older doctors and retirement. Medical Journal of Australia, 206: 202-203. https://doi.org/10.5694/mja16.01424

[33] Medical Board Expert Advisory Report on Revalidation, 2017, https://www.medicalboard.gov.au/Professional-Performance-Framework/Evidence-and-supporting-documents.aspx

[34] Choudhry NK Fletcher RH Systematic Review: The relationship between clinical experience and quality of health care. Ann Intern Med 2005;142: 260-273

[35] Ilene N. Moore, *Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory?* 28 Health Matrix 95 (2018) Available at: https://scholarlycommons.law.case.edu/healthmatrix/vol28/iss1/14

[36] Ebaid, D., & Crewther, S. G. (2020). Time for a systems biological approach to cognitive aging?—a critical review. *Frontiers in Aging Neuroscience, 12,* Article 114. https://doi.org/10.3389/fnagi.2020.00114)

[37] Harrington KD, Schembri A, Lim YY, Dang C, Ames D, Hassenstab J, Laws SM, Rainey-Smith S, Robertson J, Rowe CC, Sohrabi HR, Salvado O, Weinborn M, Villemagne VL, Masters CL, Maruff P, 2018. Estimates of age-related memory decline are inflated by unrecognized Alzheimer's disease. Neurobiol. Aging, 10.1016/j.neurobiolaging.2018.06.005

[38] Casaletto KB, Elahi FM, Staffaroni AM, Walters S, Contreras WR, Wolf A, Dubal D, Miller B, Yaffe K, Kramer JH. Cognitive aging is not created equally: differentiating unique cognitive phenotypes in "normal" adults. Neurobiol Aging. 2019 May;77:13-19. doi: 10.1016/j.neurobiolaging.2019.01.007. Epub 2019 Jan 24.

[39] Mella N, Fagot D, Renaud O, Kliegel M, de Ribaupierre A, 2018. Individual Differences in Developmental Change: Quantifying the Amplitude and Heterogeneity in Cognitive Change across Old Age. J. Intell 6, 10, 10.3390/jintelligence6010010

[40] Stern Y, Barnes CA, Grady C, Jones RN, Raz N. Brain reserve, cognitive reserve, compensation, and maintenance: operationalization, validity, and mechanisms of cognitive resilience. Neurobiol Aging. 2019 Nov;83:124-129. doi: 10.1016/j.neurobiolaging.2019.03.022. PMID: 31732015; PMCID: PMC6859943.

[41] Lamont RA, Swift HJ, Abrams D. A review and meta-analysis of age-based stereotype threat: negative stereotypes, not facts, do the damage. Psychol Aging. 2015 Mar;30(1):180-193. doi: 10.1037/a0038586. Epub 2015 Jan 26. Erratum in: Psychol Aging. 2018 Aug;33(5):vi. doi: 10.1037/pag0000269.

[42] Riboni FV, Pagnini F. Age-Based Stereotype Threat: A Systematic review of priming techniques and theireffects. Innov Aging. 2019 Nov 8;3(Suppl 1):S455–6. doi: 10.1093/geroni/igz038.1705. PMCID: PMC6840765.

[43] Barber, SJ The Applied Implications of Age-Based Stereotype Threat for Older Adults, Journal of Applied Research in Memory and Cognition, Volume 9, Issue 3, 2020, Pages 274-285, ISSN 2211-3681, https://doi.org/10.1016/j.jarmac.2020.05.002.

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?

We do not support the introduction of mandatory assessment. Our findings (see detailed analysis document as part of this submission) reveal that there is no evidence in the CRIS document to support the introduction of mandatory assessment for late career doctors.

The 2023 Ahpra data (CRIS) show that a very small proportion of registered doctors over 70 had notifications with Ahpra that led to regulatory action. We estimate 90 doctors or 1.3% of the total 6,975 registered doctors over 70. Even fewer had complaints related to health impairment – 18 notifications.

Our analysis shows that the absolute number of doctors with notifications under 70 far exceeds those over 70. On the basis of numbers of notifications, there is more threat to public safety from doctors under 70 who show impaired practice, assuming notifications data is a valid reflection of this. Our analysis reveals increased notifications and 'impairment' risks in IMGs and a higher number of mental illness and substance misuse notifications in doctors aged 36-60 (Thomas et al.) It is discriminatory to select one group for mandatory testing over others.

If mandatory assessment is introduced, it should apply to all doctors irrespective of age.

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.

The best model is Option 1: Rely on existing guidance, including Good medical practice: a code of conduct for doctors in Australia (Status quo).

The are mechanisms currently in place to identify and address impairment in doctors of all ages, including health checks with GPs as part of the code of conduct.

The Senate inquiry into Ahpra's management of notifications reveals there is much to be improved in this area too and that assessment of notifications needs to be better handled. There can be improvements to more effectively monitor doctors who have a record of multiple notifications, which is a known risk factor (Bismark et al.). Multiple notifications may be an indicator of a performance issue at all ages. Number of notifications is likely a better way to identify doctors who pose a problem rather than mandatory screening of all doctors, the majority of whom do not have issues; with the caveat that 70-85% of notifications are found to be unsubstantiated.

The CRIS document does not provide unbiased evidence to support either Option 2 or Option 3. Both these options undermine the professional standing and confidence of the vast majority of late career doctors who do not receive complaints leading to regulatory action. The use of mandatory cognitive testing as a screening tool has no support in the literature.

A concerning feature of the CRIS document is the level of ageism that is inherent in its portrayal of late career doctors. Many of the statements around health and cognitive impairment are not borne out by current research and serve to perpetuate the stereotype of older age as synonymous with impairment. The WHO Global Report on Ageism finds that 'ageism is prevalent, deeply ingrained and more socially accepted than other forms of bias' and that 'globally, one in two people are ageist against older people'. Age discrimination commissioner Kay Patterson calls ageism "the least understood form of discriminatory prejudice" and "more pervasive and socially accepted than sexism and racism". We note the following comment by Barber:

"aging stereotypes have actually become more negative in recent years … we "are edging closer to accepting a new stereotype that cognitive function falls off in midlife". In accepting this stereotype as truth, we may be spreading an "epidemic of fear"… in which the current generation of older adults is experiencing heightened concern about their own abilities as they age."

Institutional policies and practices that perpetuate stereotypical beliefs about older people constitute 'institutional ageism' and, if left unchecked, drive ageist policies.

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.

The growing evidence shows that there is no stable basis for arguing that cognition necessarily declines with chronological age and that, in measuring cognitive resources, one must be clear about the abilities being measured, how they are measured, the people they're being measured in, and what their relevance is to practice. Many researchers are adopting the premise that cognitive ageing is biologically-driven rather than chronologically-driven and that explanations and measurements of cognitive changes are under-developed at this time. Rather than promulgating a deficit model of cognitive resources, there is growing research on how cognitive resources are maintained and enhanced with appropriate lifestyle and health choices across the lifespan.

There is clear evidence that older adults' memory and cognitive performance is negatively affected by threat from age stereotypes, and that these effects persist across gender and age groups (within later life). The effect of Aged Based Stereotype Threat (ABST) has been documented for over a decade with research showing that older people can be vulnerable to ABST when they perform memory, cognitive, or physical tests, with the result that they underperform.

Mandatory testing is likely to exacerbate underperformance, particularly when the testing is seen as punitive and used to establish baselines against which future performance is to be measured, as in the MBA recommendation. Distinguishing between underperformance due to impairment and underperformance due to ABST is problematic.

It is not clear that, in the case of a complaint, doctors will not be asked to provide their health check information as evidence of their level of competency or that the information will not be used to argue for impairment in the doctor. These possibilities mean that any testing is likely to be a highly stressful event.

If a baseline cognitive test is performed at age 70, it will be followed up at age 73 and 76. These test results could be adversely affected by Aged Based Stereotype Threat giving an erroneous suggestion of deterioration. Understanding the impact of stress, ABST and other factors in the interpretation of test results is not guaranteed and likely to pose a problem.

In relation to the MMSE, the CRIS document states, "A study of older people with greater education showed a MMSE score of less than 28 was more sensitive in detecting impairment than the standard threshold of 23 or less". The reference by O'Bryant, both in the conclusion and text, in fact uses a cutoff score of 27 meaning 26 or lower - "This cutoff has an optimal balance between sensitivity and specificity". The CRIS document argues for the use of MMSE and the ACE-III and in the case of the former using higher cutoff scores to diagnose impairment. The CRIS document misrepresents the cutoff score for the MMSE in the O'Bryant article. Using a non-validated cut off score to screen doctors is highly problematic. There are no established norms for medical doctors for the MMSE nor ACE-III.

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.

All health checks of any nature should be confidential between patient and doctor. They should not be shared with the Board.

Allied health, practice staff, and nursing staff should not participate in assessments or have access to results nor should other medical colleagues in practices be able to access confidential information. Recording of confidential mandatory assessments is likely to require unique software or separate record keeping. Breaches should attract significant penalties.

Given that cognitive tests are proposed to be done 3 yearly there would be an expectation that the assessing/treating doctor is able to interpret any change that might occur. In the absence of adequate understanding of the factors (e.g., Age Based Stereotype Threat) that may impact results, it is likely that impairments will be over diagnosed.

It is unclear how confidentially can be maintained when assessment is mandatory.

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. The Board is a regulator and should not be engaged in this activity.

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?

The draft registration standard as it stands should not be implemented.

Otherwise, the draft registration standard should be amended

1. to apply to all doctors, irrespective of age.
2. to exclude cognitive assessment

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

The draft registration standard as it stands should not be implemented.

Otherwise, the draft registration standard should be amended

1. to apply to all doctors, irrespective of age.
2. to exclude cognitive assessment

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

The draft registration standard as it stands should not be implemented.

Otherwise, the draft registration standard should be amended

1. to apply to all doctors, irrespective of age.
2. to exclude cognitive assessment

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?

The documents are clear, but are not relevant as shown below.

Doctors over 70 who received notifications with Ahpra leading to regulatory action in 2023 are a very small percentage of the late career doctors (n=6,975) – we estimate around 90 doctors (see our analysis). Notifications for *health impairment* are also very low – 18 out of 485 unsubstantiated complaints (see Table 10 in our analysis).

The use of mandatory screening of all late career doctors (6,975) is a disproportionate action given these low numbers and the much higher numbers of doctors under 70 who receive complaints leading to regulatory action.

The supporting resources fail to address the issues for IMGs which overshadow any purported age-related problems. The references used in the CRIS document (Peisah 2007, Kataria 2014, Khaliq 2005, Donaldson 2014) clearly demonstrate an increase in notifications for International Medical Graduates (IMGs). The CRIS document fails to address this and misrepresents findings on IMGs as findings for late career doctors.

Reduced scores on cognitive tests were also found for doctors under 60 and for IMGs, for whom, as the authors of one reference point out, problems with English are likely to have affected their results.

It is important to note that doctors who were showing signs of 'impairment' were referred for diagnostic testing not the other way around. Tests were not used as screening measures and there is no evidence that they should be used in this way.

Apart from languages spoken, there is no question about country where the medical degree was obtained.

8.2. What changes would improve them?

As previously stated, there is not enough emphasis on confidentiality. It would require changes to practice software and/or the way records are kept and accessed.

We are concerned that, as with Over 75 health checks, that assessments may be relegated to nursing staff. This is a major concern for privacy and competency of assessor.

What will prevent the practice staff, including other doctors, from accessing any or all this information? What prevents individuals leaking information about doctors' assessments to others, for example, in a vexatious complaint?

The proposed registration standard will open up further avenues of information abuse and unfounded and spurious reporting to the regulator; as a recent Senate Inquiry identified currently already exists.

Doctors may be pushed to seek out other practices where they might not be known. This may result in doctors NOT seeing their regular GPs who would have a more complete record and understanding of the doctors' health status.

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

No.

The information required is much more intrusive than that required for a 'health check'. Questions are so intrusive that they are unlikely to register accurate responses because to do so may result in punitive action.

The assessment reflects regulator oversight rather than a health check aiming to assist the practitioner. Normal GP Health checks in the context of a trusted relationship take into consideration far more nuanced information and a sensitive approach to health issues.

As identified in 1.4, the questions on 'alcohol and substance review' would be better addressed in a cohort aged 36-60 who show more notifications for *mental illness and substance misuse* in the Thomas et al. article on which the MBA has based its argument (see the detailed analysis document). It is unclear why this group has not been targeted for mandatory health assessment.

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

No.

The normal GP health check is adequate to screen for major health issues and is part of the code of conduct for medical practitioners.

The cognitive tests are not appropriate. There are no norms for doctors for any of the tests shown.

References used to argue for cognitive testing are misrepresented in the CRIS document. The Peisah reference applies to doctors who were referred to an impaired registrants' program, so tests were diagnostic not screening. The age was 60 or over (not 70) and 53% were IMGs. Issues were identified by existing modes of referral, not screening. The mean MMSE for the group was 28 in those tested (14/41 tested). The cutoff score being proposed by the MBA does not conform with the findings of the Peisah study.

The tests being suggested for screening are essentially diagnostic tests to be used in people who are considered to have MCI (mild cognitive impairment). Used as a screening test over a large population (approx. 7,000 doctors over 70), there is no data on sensitivity, specificity, or positive and negative predictive value (PPV & NPV).

This means that with a low prevalence of MCI there will be increased false positives. False positives mean that a number of doctors will be incorrectly diagnosed, have their registrations impacted through false reporting, be subjected to further assessment, and experience personal and professional stress (see the Senate Inquiry findings regarding impacts).

There is a concern, that as with unfounded complaints, there is likely to be a devastating impact on a number of doctors, disproportionate to the risk to public safety, as noted by the Senate Inquiry:

> 'The committee heard that the impact the notifications process has on the health and wellbeing of practitioners is disproportionate to the risk to public safety.'

The section on alcohol and substance use is clearly written from a regulator perspective. If this area needs to be covered, then the board should consider testing all doctors as the evidence from Thomas et al. in the CRIS document clearly shows a higher percentage of notifications in *substance misuse* (as well as *mental illness*) in the under 36-60 age group. Absolute numbers are 16 times higher in the younger group (see our detailed analysis of Thomas et al.)

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

Given the lack of appropriate norms for doctors for the tests being proposed, as well as issues with sensitivity and specificity, there should be no implementation until these are adequately addressed in the academic literature through independent research.

This research should have no association with the regulator, as has been the case in studies referenced in the CRIS document (i.e., Studdart, Bismarck, Spittal), which show bias to the regulator's perspective (see our detailed analysis).