Your details

Name: Jennifer Jill Gordon

Organisation (if applicable):

Are you making a submission as?

- ☐ An organisation
- ☒ An individual medical practitioner
- ☐ Other registered health practitioner, please specify:
- ☐ Consumer/patient
- ☐ Other, please specify:
- ☐ Prefer not to say

Do you give permission to publish your submission?

- ☒ Yes, with my name
- ☐ Yes, without my name
- ☐ No, do not publish my submission

Feedback on the Consultation regulation impact statement

The Medical Board of Australia is consulting on three options to ensure late career doctors are able to keep providing safe care to their patients.

The details of the options for consideration are contained in the consultation regulation impact statement.

1. Should all registered late career doctors (except those with non-practising registration) be required to have either a health check or fitness to practice assessment?

If not, on what evidence do you base your views?

Yes – all registered, late career practitioners should have a fitness to practice assessment. Because of the trajectory of cognitive decline (and because of limited resources), a fitness to practice assessment could be introduced as a baseline screening at 70, and then at 75, 78 and annually from 80.

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?

Begin at age 75 and assess the impact before deciding whether to progressively reduce the age to 70 as suggested above.

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.

Option 2 will provide the best model. as the major focus, with recommendations only for elements of Option 3

Option 1 does nothing to solve the current problem

Option 3 is easily "gamed" by doctors who are buddies with their GPs. Encourage/recommend it if you like

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?

Yes – as a means of charting the maintenance of, or decline in, cognitive function.

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.

1. The appropriate health checks should be conducted by **an independent assessment team.**

2. The assessment team should have a legal responsibility to make a report. The report should declare any cognitive impairment likely to detrimentally affect practice but need not specify the nature of the deficit. (Note that this approach adds an additional administrative burden on the Board, but is the only sure way of maintaining medical confidentiality)

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?

The Board should certify cognitive assessment teams, in order to ensure that the “buddy” problem does not arise.

Feedback on draft Registration standard: Health checks for late career doctors

This section asks for feedback on the Board's proposed registration standard: Health checks for late career doctors.

The Board has developed a draft Registration standard: health checks for late career doctors that would support option three. The draft registration standard is on page 68 of the CRIS.

1.1. Is the content and structure of the draft Registration standard: health checks for late career doctors helpful, clear, relevant, and workable?

It is clear, but I would be opposed to the idea of a doctor declaring that their assessment results were positive. How would you know if a doctor made a false declaration? Unless the assessor submits the result of the assessment in some form or other, it is open to misuse.

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

No

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

No

Draft supporting documents and resources

This section asks for feedback on the draft documents and resources developed to support Option three - the health check model.

8. The Board has developed draft supporting documents and resources (page 72 or the CRIS). The materials are:

   C-1 Pre-consultation questionnaire that late career doctors would complete before their health check

   C-2 Health check examination guide – to be used by the examining/assessing/treating doctors during the health check

   C-3 Guidance for screening of cognitive function in late career doctors

   C-4 Health check confirmation certificate

   C-5 Flowchart identifying the stages of the health check.

   The materials are on page 72 of the CRIS.

2.1. Are the proposed supporting documents and resources (Appendix C-1 to C-5) clear and relevant?

Yes

2.2. What changes would improve them?

Because I fundamentally disagree with the approach, further comment on details is inappropriate. Can you honestly say that each of the items on the pre-consultation questionnaire is relevant to the delivery of good quality medical care? Clearly not!

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

Way, way, way too excessive. It's up to the Board to demonstrate how eg a genital exam relates to the practice of medicine. This is getting ridiculous - Big Brother on steroids!

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

No. The only thing that really matters (and is any of the business of the Board) is whether or not a late career doctor has the cognitive capacity (including self-insight, etc) to continue safely and productively in practice.

If you're serious, you'll set up a limited but accessible number of specialised assessment teams focusing their attention on valid, reliable and detailed cognitive assessments, and stop wasting everyone's time with the broad-ranging, largely useless assessment of other body systems.

Don't forget that if you counsel an older doctor with a physical impairment to retire, you'd better be ready to counter charges of "ableism" by younger doctors who have physical impairments and practise quite successfully.

Stop this madness!! Focus on what matters!

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

As stated, the main resource needed is an accessible assessment service that does valid, reliable, detailed cognitive assessments and makes the results known to the Board, which then notifies the doctor as to whether or not they have passed the assessment. A doctor can then appeal the decision and be re-examined, but few will do so. If the assessment charge reflects the true cost of the system, some older doctors may decide to save both face and money and retire – so much the better if they do. The approach that I'm suggesting avoids what is seen by many as bureaucratic interference that serves no good purpose in ensuring patients' wellbeing.

I am 77 and my husband is 77. We are in part-time practice, winding down, year after year, restricting ourselves to the things that we know we can do well. Some of our contemporaries who are still in practice will bridle at the perceived interference. They will incite criticism that the Board can well do without. Why not make this whole process rigorous and unassailable?