From: [redacted]
Sent: Friday, October 4, 2024 1:11 AM
To: medboardconsultation <medboardconsultation@ahpra.gov.au>
Subject: Health checks for late-career doctors: alternative suggestion for assessing aging medical practitioners

Dear Dr Tonkin,

Thank you for the opportunity to respond regarding health checks for late-career doctors. I'm currently out of Australia and cannot download the submission forms in either format. Thus this email, with apologies.

I would prefer that this submission remain anonymous for the time being, as the measurement tool suggested below is not finished.

I agree that health practitioners need to stop treating patients before the practitioner suffers performance degradation. But rather than using cognitive deterioration as a surrogate for impaired practice, I think that measuring actual performance with peer comparison gives clearer insight.

In addition, the numerous specialists consulted about this approach were all very keen to participate.

I understand this does not cover GPs in its present form.

Suggestion:
My suggestion is to use risk adjusted hospital coding data to allow practitioners and health system operators see whether they are performing at the same level as their peers or below (or above). If substandard performance is shown, the individual can remedy this according to predetermined pathways. The system operator can also keep an overview and act as necessary.

My background:
I am a 66 year-old retired interventional radiologist / interventional neuroradiologist who has worked in both private and public hospital settings. Throughout my career, I had given consideration to the timing of retirement to avoid underperformance. I electively chose age 62, predominantly because there was no good measurement system that I could use to guide me.

In the last few years of my public hospital career, I was included in the newly formed Metro North Health (Queensland Health) value based healthcare team. The team made significant progress in developing the clinical outcomes measurement system mentioned above. Unfortunately, this work and the creation of both a mobile phone app and desktop system was stymied by the appearance of Covid and the re-demployment of resources. I then retired and the work remains unfinished. All parties involved were very keen to finish and use the system.

Using coded data to measure clinical outcomes: where did we get to?

Adverse outcomes were defined by hospital acquired complications (HACs) plus approximately 20 other adverse outcomes as decided by a reference group of specialists from a wide range of disciplines. The reference group asked for adverse outcomes they had specific interest in measuring and that they felt were good indicators of clinical performance.

Outcome data came from all hospital coded admissions. Additional data sources were found for all of the other clinical questions posed by the clinician reference group. Very diverse sources were found, such as

death data directly from the Queensland registry of births, deaths and marriages. We even tried to obtain nursing home admission data from the federal government, but this was not forthcoming.

Accuracy of the coded data was analyzed by multiple types of audits. It was determined that the data was more than 90% accurate regarding significant positive and negative outcomes. Coding was completed and audited by 1 month post hospital discharge, so the data was current.

Risk adjustment was performed so clinicians would be comparing outcomes while making allowance for patient differences ie "comparing apples with apples". Coded data from 800,000 consecutive hospital admissions (3 years of Metro North Health data) was then analysed by an external academic statistical unit to create the risk adjustment.

To allow clinicians to query the database, CSIRO eHealth provided a mapping tool that would allow clinicians to use standard medical terms to search the coded data (which has quite complicated terminology).

So by this stage, we had accurate risk adjusted data sources and a clinically relevant way for clinicians to assess this database. We were just commencing work on results display when the work had to cease due to redeployment of staff to Covid activities.

I think this may be a very useful tool for AHPRA, but it would require completion, presumably under the auspices of AHPRA.

I would be very pleased to answer any further questions you may have.

Thank you again.

Regards

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