Your details

Name: Prof Philip Morris AM

Organisation (if applicable): National Association of Practising Psychiatrists

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- ☐ No, do not publish my submission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?

No. The Medical Board of Australia should improve its monitoring of doctors who have a track record of being at risk. In other words, improving the application of Option 1 in the Board's proposal. See evidence below.

The Medical Board of Australia proposes to mandate repeated medical examinations and cognitive testing on doctors based on a single characteristic of being aged 70 and on an unproven negative stereotypical assumption that these doctors are a risk to patient welfare just because of their age [1].

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

Notifications

The Board justifies this proposal on the rate of notifications (unsubstantiated complaints) to the Australian Health Regulation Authority (Ahpra) of registered Australian doctors. The Board claims that the higher rate per 1000 doctors of notifications for doctors aged 70 (older doctors) and over compared with doctors below age 70 (younger doctors) indicates that these older doctors pose a risk to public safety.

The Board notes [1] that the rate of notifications (per 1000 doctors) for older doctors is about 1.5 to 1.8 times the rate for younger doctors, and that the rate for older doctors increased from 2015 to 2023. While the rate of notifications increased from 2015 to 2019, this increase was the same for both younger and older doctors: 70% and 73% respectively. From 2019 to 2023 the rate of increase in notifications plateaued; there was a small decline of 3% for younger doctors and only a modest increase of 9% for older doctors (Table 1).

The Board notes there has been an increased number of notifications from 2015 to 2023 for doctors aged 70 and older [1]. Using the Board's own data the number of notifications for older doctors (age 70 and above) was 189 in 2015, 380 in 2019, and 485 in 2023 (see Table 1). In 2023 the number of notifications for older doctors as a proportion of all registered older doctors was 6.9%. Regulatory action was taken against just 23% of the doctors who received notifications. These data indicate that just 1.5% of all older doctors experienced a regulatory intervention in 2023. However, in 2023 the number of notifications for younger doctors (under age 70) was substantially higher at 4,765. On an absolute level, the number of notifications for younger doctors was ten times higher than for older doctors (Table 1).

The pattern of increased rate of notifications from 2015 to 2019 and then a reversal of this pattern from 2019 to 2023 was seen in the category of Clinical Care notifications. The rate of notifications increased 190% from 2015 to 2019 among younger doctors and increased 222% for older doctors. But, from 2019 to 2023 the rate of notifications in this category declined by similar amounts for both younger and older doctors: 28% and 22% respectively (Table 1).

Other than providing broad categories of notifications, the Board does not provide (deidentified) details of the nature of the notifications made against older doctors, or how these notifications put patient care at risk, and nor does the Board provide details of how many notifications were substantiated and how many doctors received multiple notifications. This information is vital to determine whether older doctors as a group pose an unacceptable threat to the public or are more of a risk than younger doctors.

The nature of regulatory action taken by the Board in 2022-23 was much more severe (requiring suspension, fines and reprimands) for younger doctors than older doctors. 34 younger doctors required sever regulatory action whereas no older doctor need this intervention (Table1), suggesting that the younger doctors presented a greater risk to the community.

In summary, there is no evidence in these data that there is an explosion of notifications among older doctors. The change in the rate of notifications is similar between younger and older doctors. The rate of notifications increased about 70% in both groups between 2015 to 2019 and then flattened out to 2023.

The explanation for this pattern is not clear, but given it was observed in both groups and is of the same magnitude, it is likely that for the period 2015 to 2019 it related to changes in reporting such as the start of health ombudsmen

offices in states, encouraging the public to consider making complaints to health regulators, as well as making notifications easier via electronic means. The data do not support the notion that the rate of notifications for older doctors are continuing to increase or rise disproportionally.

Table 1

Year	2015	2019	2023
Notifications - older doctors	189	380	485
Notifications - younger doctors	Not provided	Not provided	4765
Rate – older doctors	36.2/1000	62.8/1000 (+73%)	69.5/1000 (+9%)
Rate – younger doctors	23.4/1000	39.8/1000 (+70%)	38.3/1000 (-3%)
Rate – clinical care - older doctors	9.7/1000	31.3/1000 (+222%)	24.2/1000 (-22%)
Rate – clinical care - younger doctors	7.6/1000	22.2/1000 (+190%)	15.9/1000 (-28%)
Year			2022-23
Fine or reprimand or suspension – N and % of notifications			
Older doctors - N - %			0 0.00%

Younger doctors - N- %			34 0.72%

Further Evidence Needed

If the Board wanted to provide more convincing evidence to justify its proposal to mandate medical examinations and cognitive testing for older doctors, the Board should commission a properly designed study or survey of doctors across different age cohorts examining their physical health, mental health, substance use, and cognitive status, and their capacity to examine and treat patients competently. In addition, the Board should conduct a properly designed trial comparing the Board's preferred model of repeated medical and cognitive examinations for older doctors with current arrangements.

Only after a survey identified problematic performance of older doctors, and a trial demonstrated the superiority of the Board's preferred examination of older doctors on reducing risks to patients and improving the health of older doctors, could the Board legitimately argue for mandatory medical examinations and cognitive testing of these doctors.

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

Health committees of medical boards across Australia are generally aware of those doctors who have impairments based on underlying medical conditions. A report from an Australian medical board noted that there is no significant difference in the proportion of doctors over age 60 among doctors known to these committees [2]

In view of all this evidence, there is no substantial indication that older doctors as a group pose a significant risk to the public. The Board's age profiling of older doctors is not sufficient grounds to mandate physical examinations and cognitive testing for these doctors.

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?
Any health checks for late career doctors should start at age 75, an age consistent with medical checks for older age motor vehicle drivers.

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.

An enhancement of Option 1. See evidence below.

The Way Forward – Improving Current Arrangements

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

The Board claims that current regulatory measures are failing to detect some practitioners with health issues, and this therefore increases the risk to patients. But the Board provides no robust evidence that supports this claim apart from age profiling older doctors.

The Board already has extensive and legitimate powers to assess younger and older doctors who have medical conditions that might affect their cognitive performance and clinical practice without the need to specifically target older doctors. One way the Board can identify doctors of concern is to ask doctors with two or more complaints in a defined period, or who have been reported for a significant lapse in standard of care, to undergo a health check. The Board has this capacity, and this should be the norm regardless of age. By implementing a strategy of proactively identifying doctors of concern, no

matter what age, the Board would be able to achieve its aim of reducing risk to the public without discriminating against older doctors.

Alternatively, if the Board believes it is a good idea for older doctors to have regular health checks from their general practitioners to benefit the doctor's health and to reduce the risk to the public, then this should be mandatory for all doctors regardless of age, given that younger doctors have 10 times the number of notifications than older doctors, are just as valuable individuals as older doctors, and the risk of unwell (or drug affected) doctors of any age on the public is just as important. The Board would be well advised to ask all doctors to have a regular medical check-up with their general practitioner and apply its Code of Conduct [1, page 5]:

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

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

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. See evidence below.

Cognitive Testing

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

Healthy aging is associated with subtle changes in cognition. There are gradual changes that occur in fluid intelligence and crystallised intelligence [3]. Fluid intelligence peaks in early adulthood and then declines slowly. These changes are small and gradual. The changes in fluid intelligence are counter-balanced by age-related improvements in crystallised intelligence. In healthy aging, these changes complement each other.

These changes of healthy aging have not been linked to problems in clinical practice that would lead to concerns for public safety. Studies of physician age and in-hospital patient mortality have generally shown no association with age when controlled for procedural volumes [4] and no association between physician age and patient readmission [4]. The reasons behind associations between age and specific clinical outcomes are complex and are not likely to just relate to age of physician [5].

It is important to note that individual variation is substantial in all doctors who age. There is no consensus or agreed guidelines that help medical authorities decide what level of age-related cognitive changes may put the public at risk. The Board acknowledges this significant limitation [1, page 20]:

It is difficult to relate the precise degree of neurocognitive loss to doctors' competence because the actual levels of cognitive impairment that preclude safe practice have not been determined. There are no agreed guidelines to help medical boards decide what level of cognitive impairment in a doctor may put the public at risk.

Prospective studies have not been done addressing this issue [2]. The American Medical Association in 2015 [6] noted:

the effect of age on any individual physician's competence can be highly variable,

and in 2018 it withdrew its support for testing physicians cognitively at 70 years of age [7].

The Board recommends that screening cognitive tests be used for regular testing of older doctors [1]. The tests mentioned include the Montreal Cognitive Assessment (MoCA), the Addenbrooke's Cognitive Examination (ACE-III), the Mini Mental State Examination (MMSE), and the Clock Drawing Test (CDT).

What the Board fails to mention is that these tests have not been validated specifically for assessing the capacity of physicians. There are no norms for

the cognitive screening tests they propose (MoCA, ACE-III, MMME, or Clock Drawing Test) for medical practitioners. None of these screening instruments have been evaluated to discover what scores would determine the doctor's capacity to practice. The lack of norms and the potential for test familiarity among doctors undermine the reliability and relevance of these tests in determining a doctor's professional competency.

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.

Any health checks/fitness to practice assessments must be confidential between the late career doctor and their assessing/treating doctors and not shared with the Board.

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 encourage ALL doctors to have a personal physician and look after their health as recommended in the Board's Code of Conduct. See below.

If the Board believes it is a good idea for older doctors to have regular health checks from their general practitioners to benefit the doctor's health and to reduce the risk to the public, then this should be mandatory for all doctors regardless of age, given that younger doctors have 10 times the number of notifications than older doctors, are just as valuable individuals as older doctors, and the risk of unwell (or drug affected) doctors of any age on the public is just as important. The Board would be well advised to ask all doctors to have a regular medical check-up with their general practitioner and apply its Code of Conduct [1, page 5]:

The Board's code of conduct (Code) requires all doctors to have their own general practitioner (GP) to help them take care of their health and wellbeing

throughout their working lives. Healthy doctors are the cornerstone of Australia's healthcare system.

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.

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 is not applicable. As argued above, there is no place for a discriminatory Registration standard of this type based on age profiling. If the Board wishes to require doctors to undergo health checks it should enforce its Code of Conduct and require ALL doctors to undergo these checks, not just late career doctors (see below). There is no place for cognitive testing of late career doctors for the reasons outlined below.

If the Board believes it is a good idea for older doctors to have regular health checks from their general practitioners to benefit the doctor's health and to reduce the risk to the public, then this should be mandatory for all doctors regardless of age, given that younger doctors have 10 times the number of notifications than older doctors, are just as valuable individuals as older doctors, and the risk of unwell (or drug affected) doctors of any age on the public is just as important. The Board would be well advised to ask all doctors to have a regular medical check-up with their general practitioner and apply its Code of Conduct [1, page 5]:

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Cognitive Testing

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

Healthy aging is associated with subtle changes in cognition. There are gradual changes that occur in fluid intelligence and crystallised intelligence [3]. Fluid intelligence peaks in early adulthood and then declines slowly. These changes are small and gradual. The changes in fluid intelligence are

counter-balanced by age-related improvements in crystallised intelligence. In healthy aging, these changes complement each other.

These changes of healthy aging have not been linked to problems in clinical practice that would lead to concerns for public safety. Studies of physician age and in-hospital patient mortality have generally shown no association with age when controlled for procedural volumes [4] and no association between physician age and patient readmission [4]. The reasons behind associations between age and specific clinical outcomes are complex and are not likely to just relate to age of physician [5].

It is important to note that individual variation is substantial in all doctors who age. There is no consensus or agreed guidelines that help medical authorities decide what level of age-related cognitive changes may put the public at risk. The Board acknowledges this significant limitation [1, page 20]:

It is difficult to relate the precise degree of neurocognitive loss to doctors' competence because the actual levels of cognitive impairment that preclude safe practice have not been determined. There are no agreed guidelines to help medical boards decide what level of cognitive impairment in a doctor may put the public at risk.

Prospective studies have not been done addressing this issue [2]. The American Medical Association in 2015 [6] noted:

the effect of age on any individual physician's competence can be highly variable,

and in 2018 it withdrew its support for testing physicians cognitively at 70 years of age [7].

The Board recommends that screening cognitive tests be used for regular testing of older doctors [1]. The tests mentioned include the Montreal Cognitive Assessment (MoCA), the Addenbrooke's Cognitive Examination (ACE-III), the Mini Mental State Examination (MMSE), and the Clock Drawing Test (CDT).

What the Board fails to mention is that these tests have not been validated specifically for assessing the capacity of physicians. There are no norms for the cognitive screening tests they propose (MoCA, ACE-III, MMME, or Clock Drawing Test) for medical practitioners. None of these screening instruments have been evaluated to discover what scores would determine the doctor's capacity to practice. The lack of norms and the potential for test familiarity among doctors undermine the reliability and relevance of these tests in determining a doctor's professional competency.

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

Any health checks for late career doctors should start at age 75 years, not at age 70.

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

This draft registration standard is not required for the reasons argued earlier.

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.

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

The supporting documents concerning cognitive testing are not applicable for the reasons outlined below. They should be removed as cognitive testing in this setting is both invalid and unreliable. See below.

Cognitive Testing

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between physician age and patient readmission [4]. The reasons behind associations between age and specific clinical outcomes are complex and are not likely to just relate to age of physician [5].

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What the Board fails to mention is that these tests have not been validated specifically for assessing the capacity of physicians. There are no norms for the cognitive screening tests they propose (MoCA, ACE-III, MMME, or Clock Drawing Test) for medical practitioners. None of these screening instruments have been evaluated to discover what scores would determine the doctor's capacity to practice. The lack of norms and the potential for test familiarity among doctors undermine the reliability and relevance of these tests in determining a doctor's professional competency.

The health questionnaire to be completed by the doctor patient is reasonable in most respects, but the questions about cognitive testing (below) should be removed as they do not provide meaningful information.

'deterioration in serial cognitive testing (if done)'
'any cognitive testing'

Apart from the patient details and general vital signs (weight, heart rate and rhythm, and blood pressure), the health check examination guide is far too extensive, and it is a potential violation of a doctor patient's privacy – what male or female or non-binary doctor is going to be comfortable with an enforced genital examination? The cognitive testing component of the examination should be eliminated for the reasons set out below. The health check examination should be a symptom-directed examination, based on the information from the health questionnaire and the examining doctor's history taking.

Cognitive Testing

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8.2. What changes would improve them?

The supporting documents concerning cognitive testing are not applicable for the reasons outlined below. They should be removed as cognitive testing in this setting is both invalid and unreliable. Nothing can be done to improve them.

Cognitive Testing

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

The health questionnaire to be completed by the doctor patient is reasonable in most respects, but the questions about cognitive testing (below) should be removed as they do not provide meaningful information.

'deterioration in serial cognitive testing (if done)'
'any cognitive testing'

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

Apart from the patient details and general vital signs (weight, heart rate and rhythm, and blood pressure), the health check examination guide is far too extensive, and it is a potential violation of a doctor patient's privacy – what male or female or non-binary doctor is going to be comfortable with an enforced genital examination? The cognitive testing component of the examination should be eliminated for the reasons discussed previously. The health check examination should be a symptom-directed examination, based on the information from the health questionnaire and the examining doctor's history taking.

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

None.