Your details

Name: [redacted]

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- ☐ No, do not publish my submission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 – a fitness to practice assessment, but not simply a health check. There should be something more holistic (borrowing aspects of GMC UK revalidation). Being 'healthy' doesn't stop you being out of date or practicing poorly.

I'm not convinced that it is failing cognition that leads to a disproportionate number of complaints from older doctors; more likely too many years since graduation, inadequate CPD and not enough reflective practice.

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?

I'd link it to age you can get an aged pension (currently 67), or maybe another existing framework (commercial pilot schedules, vocational driving licence, etc).

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.

See 1. There should be a holistic assessment of ability to practice (including a review of any health impairments) undertaken by an independent peer from the same specialty.

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?

Again, I think there's too much emphasis on 'health'. This seems like an easy option because if focuses on a medical model that most of us are comfortable with. A holistic screen (with the necessary preparation of evidence) would weed out those with declining 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.

No - 1) it's too high trust (good old boys seeing their mates of a similar vintage) and 2) the examining doctor has an obligation to report impairment in any event.

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?

Yes – there should a licence to practice system and mandatory revalidation – and the older cohort could be a pilot for similar assessment for revalidation for all doctors. It could be brought in incrementally – start at the over 67s, then bring in for all doctors (e.g. every five years) in a gradual process.

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?

This is too high trust – and too focused on 'health'.

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

Evidence of truly reflective practice – e.g. prescribing data, CPD, audit, 360-degree feedback, etc

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

This is the time to bring a holistic assessment of doctor fitness to practice (i.e. a licence to practice) – using the best elements of the UK's revalidation scheme.

I wonder how the Board will avoid claims of 'ageism'. If older doctors completed their existing registration renewals honestly would this even be a problem? (In which case, how is this proposal going to weed out any other than the obviously unwell/demented?)

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?

No – too reliant on doctor honesty and recall.

No real link to an evidence base.

8.2. What changes would improve them?

Abandon – focusing on health and not quality of practice is fundamentally the wrong approach to the problem.

In the real world 'function is everything'. Relegate health to a component of reassessment (revalidation) but don't make health the only measure.

This is a box-ticking, lazy way of undertaking a clinical history and exam.

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

No

- encourages 'box ticking' where everyone knows the 'correct' answer
- assumes insight
- suggests non-evidence based interventions (prostate screens, skin checks, etc)
- lots of responses are pretty subjective e.g. 'have you had enough exposure to sunlight for vitamin D sufficiency'
- no real link to job roll e.g. a psychiatrist could have virtually no dexterity; an indwelling urinary catheter for BPH would still allow most doctors to practice safely (claims for disability discrimination as well as age discrimination?)

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

No

- again, doesn't link to job roll. Does poor dexterity stop good practice from a psychiatrist?
- what about informed dissent – e.g. untreated hypertension – may run the risk of long-term problems, but in the short term unlikely to affect practice
- is there an evidence base or any supportive experience from another jurisdiction?

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

Are there enough occupational physicians in Australia?
How do you ensure genuine independence of the examining doctor?