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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
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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. You are missing the entire point: the biggest impediment to the delivery of high-quality care is burnout. The statement that people in their 20's are more mentally agile may be true for some tasks, but in medicine experience is everything – accumulated knowledge and a set of reflexes that cannot be imparted, other than through time, hopefully spent in a safe environment where errors can be intercepted. You cannot possibly replace someone in their early 70's with a recent graduate.
There is a generation trend – younger doctors write better notes and work to a higher standard because such practices had been taught to them. For instance, an older doctor may miss Wellen's syndrome because it was never taught 40 years ago, but is taught now, and new modalities that take time to be accepted by the profession, for instance, coronary artery CT angiograms, are already "programmed" into younger graduates.

Burnout cannot be effectively dealt with because restricting health professionals with it in any manner will be the final straw for the workforce. There is no treatment for burnout if someone continues to work impossible hours, let alone doing so in a position of high responsibility. Younger graduates are actually more prone to burnout because their circumstances usually prevent them from implementing the definitive solution, namely to leave the environment which caused burnout.

Lack of experience exacerbates burnout, and I emphasize the quality, rather than quantity, of work done by older doctors – they not only handle a larger workload, but also do it at a more expert level, which may distort statistics purporting to show their incompetence. If one acts as an obligate referologist, they won't get any complaints about their competence, but that comes at a cost of unnecessary delays and frequently, unnecessary investigations (not to mention avoidable expense).

Additional point – the overall numbers of complaints does not lend itself to proper statistical analysis, and given these low numbers, I believe that the esteemed Board needs to perform a more in-depth analysis of who attracts more complaints, including considerations other than age.

I don't believe that any examiner would be capable of determining who is safe to practice, in the absence of frank manifestations of dementia or other gross impairment. For instance, one may test memory – mine happens to be near-photographic, but I was rightly taught not to rely on it back when I was a student and write everything down.

Medicine is too complex a task to be reduced to discrete criteria, and the basic concern here is that such screening will not detect a number of disorders, unless it is stringent and has a high false positivity, the cost of which will be removal of safe or salvageable practitioners from the workforce. It may be prudent, for instance, to ask someone to refrain from tasks or scopes of practice that are a "younger person's game", where certain physical characteristics and/or instant and correct reactions are required. For instance, an older cardiologist may best refrain from procedural work and direct the main vector of his practice to manage CCF, and it is possible to monitor performance of certain tasks to detect specific age-related impairment.

Assessment of overall competence can be performed by colleagues (and very reliably). Even solo doctors have to have a working relationship with other specialists (for instance, a GP referring to a cardiologist), who may act as confidential referees. Alternatively, an assessor may work as an assistant at a practice for a short period, which would allow rapid identification of impaired practitioners.

Attendance of interactive CME events is another way to screen for cognitive decline or other impairment. A lot of CME events are vegetative in nature (eg, sitting at a lecture after a glass of wine, which I always considered ridiculous). But ALS courses (which should be compulsory anyway) are interactive and require memory, rapid reactions and instant comprehension of non-trivial concepts. Failing the same course repeatedly would signal impairment much more appropriately than a standard psychological assessment.

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?

In fact, having a GP and other relevant specialists should be a condition of medical registration. Apart from objective attendance to various complaints, a senior colleague is an invaluable source of support, even if the age gap is not significant. This can now be done remotely, and forming such a relationship needs to be heavily emphasized by AHPRA. Medical practitioners are not supposed to self-diagnose or self-prescribe, and it is accepted practice to commence routine screening at 45 years of age – anyway.

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 three is the best fit, with considerations for heavy encouragement of such health checks commencing at a much younger age.

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. Attendance of interactive CME or evidence of satisfactory practice from colleagues should be relied on instead.

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.

Definitely not shared. Same system as impaired drivers – yes or no, voluntary cessation if unsuitable, with reporting against the patient's wishes being the last resort. We really don't want to see a situation where someone with a mental health issue is driven to conceal it.

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. Ask why someone doesn't have a GP.

I get notifications in NZ: Mr X just renewed his gun licence: if he is not your patient OR if you think he shouldn't have access to firearms, let us know immediately. Which I would do – I don't want to be responsible for a massacre. Note that nobody screens gun owners for sociopathic traits in a professional manner – most jurisdictions had concluded that it cannot be done in an acceptable manner.

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?

See above comments – not overly, to all three.

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

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

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?

For answers to 1.4 to 1.8, please refer to the text of my response.

8.2. What changes would improve them?

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

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

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