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- ☐ No, do not publish my submission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?

No, they should not.
I might also ask what evidence do you have that introducing this draconian requirement will make any material difference to patient outcomes?

Introducing this would impose a requirement on medical practitioners to have a medical assessment including a cognitive assessment that is not required of any other category of worker, and is therefore blatantly discriminatory and ageist. It is equally arguable that the engineer constructing a dam, or a mine, or a lawyer or judge making a judgement, may make an error that may negatively impact on peoples lives, and yet we do not require them to do the same.

It is an invasion of privacy to be required to have a medical assessment which is then released to a third party. I in no way would consent to this and would retire. Perhaps that is your aim, to remove older practitioners from the workforce?

It is a broad brush attempt at a preemptive solution to a problem. There must be many practitioners who have never experienced any difficulty in this area, and yet everyone will be caught up in this net eventually if they work long enough. There may be younger practitioners who should have this, but won't, emphasizing that this is an ageist discriminatory policy. I predict it will lead to gross unhappiness in the profession as its impact is realized and exodus of some of the most experienced drs from the profession. People who may yet have contributed years of healthy service, passed on skills, knowledge and experience to others and continued to contribute to the speciality of medicine. These are the people I looked up to and learnt from as a medical student and junior doctor.

It goes against legal principles of an appropriate process. Normally, you are not asked to sacrifice bodily autonomy, or allow erosion or invasion of your privacy unless an incident of some type has occurred, and this too depends on the incident and its severity.

This requirement takes no account of the degree of patient interaction the practitioner has. I am a pathologist, I have minimum patient interactions. Some of my colleagues have none. Some of my colleagues work with deceased patients in coronial systems. Why do we as a group need to undergo this and what evidence is there for this requirement in such a group?

I also work in a hospital setting. I participate in CPD activities as a requirement of registration, which I submit to my college and to you annually, as a requirement for registration.
My CPD requires me to have peer review of cases. As such (and preceding this requirement in fact) it is common/everyday practice in pathology to review diagnostic cases. This has become much easier recently as a result of digital platforms that allow slide material to be viewed online and reviewed by groups of pathologists thus assuring peer review of each others work. I participate in a number of these already. They serve as a safeguard for incorrect diagnoses and the detection of cognitive issues which would likely be way more sensitive than any cognitive assessment that could be designed. I would therefore argue that what you are proposing will be useless and insensitive for its intended role, particularly noting the higher baseline cognitive functioning of practitioners.

The board would be better of requiring peer review for all practitioners, which would be less discriminatory than what you are proposing.
It is also in the nature of hospital practice that decisions are made by a group and that there are multiple contributors, and multiple pieces of diagnostic information that go into a diagnosis, including in MDTs for instance, very much reducing the likelihood of error.
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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 am opposed in very strong principal to its introduction. 70years of age is also not old.

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.

Status quo is the only acceptable response and I criticize AHPRA for allowing three responses, 2 of which are positive, thus biasing the response as more positive response options are available.

As mentioned, I think you should instead look at your CPD requirements and ensure they are inclusive enough to pick up issues with performance/ alternatively, you can respond when there is an actual incident where this assessment would be indicated. This would be fairer and less discriminatory than what you are proposing.

I also think there are some categories of drs where conceivably the risk is higher. Some of us on the other hand have minimal to no patient interaction and highly supported and collaborative public practice with review of decisions by groups of practitioners and on a departmental basis where the risk must at best be negligible. We participate in peer review and comprehensive CPD programs and this would therefore represent an unnecessary and highly intrusive requirement in such circumstances.

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Can I also posit to you the scenario where a dr has a "clean" record, but has some or other issue picked up on a medical.
What do you propose to do with that information in this scenario where no incident has occurred?
If AHPRA were to put any limitations on a drs license as a result without any evidence of harm, I feel a challenge to AHPRA would be justified.
What would be the impact on the drs standing with their insurer where no incident has occurred? would it affect premiums or ability to obtain insurance? This would be unfair in absence of any incident, but may well be precipitated by your actions.

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
it is ageist, discriminatory and unnecessary
AHPRA should respond to incidents as they do currently
What is your basis for such a proposal, how will it influence practice in different areas of medicine and how will you assess its effectiveness in sub specialist areas of medicine. I am pretty certain you have no basis for proposing this intervention on a granular sub specialist scale.

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.

Yes, of course they should be confidential. This should not be a question, the dr patient relationship is always confidential and I find it offensive that the regulator is seeking to change this.

We all make statutory declarations effectively to you annually that we have no impairment to practice and I feel this is more than adequate.
Other professions are not required to do this on the other hand and are moving to be more inclusive.

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?

Absolutely not. It is none of their business, should be confidential and I will oppose any such suggestion vehemently

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?

I oppose it

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

I oppose it

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

I feel like AHPRA has gone ahead with this and have only consulted with me when it is virtually complete. I have heard nothing from my College. Have you actually communicated with the Colleges?

I hope you can tell in my submission how much I oppose this very unfair and ageist standard, and despite all the work, I do hope you reconsider and withdraw, the medial workforce is stretched, people have already retired early due to Covid and I think you can expect a wave of more early retirements if this is imposed.
I have the potential to work overseas and will consider it as an alternative option rather than have my privacy invaded in this way

It is very unfortunate that communication is in your newsletter, which I generally don't have time to read. I feel many of my colleagues will be shocked to see this document as well.

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?

I will not be participating in any such medical assessment

8.2. What changes would improve them?

I oppose this standard

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

I oppose this standard

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

I oppose this standard

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

I oppose this standard