Public consultation - Submission

Health checks for late career doctors

7 August 2024

The Medical Board of Australia is now consulting on a proposal to introduce health checks for late career doctors.

The Consultation Regulation Impact Statement (CRIS) released by the Board seeks feedback on whether additional safeguards are needed for late career doctors (aged 70 years and older) to manage their health, including whether late career doctors should be required to have regular health checks so they can make informed decisions about their health and practice and manage the related risk to patients. The CRIS provides a summary of the Board's assessment of the impact and costs and benefits of each option.

This submission form is intended for organisations, registered health practitioners, patients and consumers.

The consultation paper, including the supporting documents, is available on the Board's website.

Submissions can be emailed to medboardconsultation@ahpra.gov.au.

The closing date for submissions is 4 October 2024.

Publication of submissions

Published submissions will include the names of the individuals and/or the organisations that made them, unless confidentiality is expressly requested.

Your details

Name:

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- ☐ No, do not publish my submission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, all registered late-career doctors should not be required to undergo a health check or fitness-to-practice assessment. The proposal oversimplifies the issue by relying solely on age as a criterion, which is not a reliable indicator of a doctor's fitness to practise. Age-based checks may promote ageism, provoke unnecessary anxiety, and potentially discourage doctors from seeking medical care due to fear of regulatory consequences. There is no independent evidence supporting that such checks improve patient safety or reduce harm. The proposal could also lead to unintended workforce shortages, especially in areas where senior doctors play key roles

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?

If a check were to be introduced, it should not be based on age but should be part of professional practice at all stages of a medical career. Setting an arbitrary age like 70 fails to account for the wide variation in doctors' health and capabilities at any age. Confidential assessments should instead be normalised throughout a doctor's career, fostering an ongoing GP-patient relationship that supports well-being without fear of regulatory oversight

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.

Enhancing Option 1 (Status Quo) provides the best model. Encouraging all doctors to maintain a relationship with a GP, and including this on the annual declaration offers the most practical and non-invasive approach. This fosters trust, encourages proactive health management, and avoids the punitive nature of mandatory assessments. Option 2 and Option 3, requiring mandatory health assessments or general health checks, are likely to cause significant workforce losses and fail to provide clear benefits to patient safety.

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, a mandatory cognitive function screening is unnecessary. Cognitive tests like the MMSE or MOCA do not fully capture the complexity of medical practice and may produce false positives, leading to unnecessary regulatory actions. The decision to undergo such screenings should remain with the doctor and their GP, based on clinical discretion. There is no evidence to support the use of this testing in this way, and until there is a validated tool that can reliably determine fitness to practise, it is not considered reasonable or ethical to introduce an unvalidated, non-evidence-based method as a proxy

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, confidentiality should be maintained to preserve the therapeutic relationship between the doctor and their GP. If doctors fear that their health disclosures will be shared with the Board, it could discourage open communication about health issues and erode the trust essential for effective medical care

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?

No, the Board should not have a more active role. Health management should be left to the doctor and their GP in a confidential setting. The Board's involvement would likely increase stress and prompt unnecessary retirements, particularly among senior doctors, exacerbating workforce shortage

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?

No, the draft standard is not workable. It lacks clarity and evidence to support the proposed mandatory health checks, and it does not address the practical challenges of implementation. The current proposal would be difficult to implement fairly, particularly in rural and under-served areas where access to GPs and specialist occupational physicians is limited. In these regions, the burden on doctors to travel for assessments, along with the associated costs, would be considerable and could deter doctors from continuing to practise.

Additionally, the proposal does not account for workforce shortages, especially in general practice and psychiatry, where many senior doctors play crucial roles. Imposing mandatory health checks may drive doctors into early retirement, exacerbating existing workforce gaps. This could disproportionately affect rural areas, where older doctors often provide the backbone of healthcare services, offering both patient care and mentoring to junior colleagues.

Without sufficient resources, support, and clear evidence that these checks improve patient safety, the proposal risks doing more harm than good. It could lead to a reduced workforce, increased pressure on remaining doctors, and decreased access to care in vulnerable regions.

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

Yes, the standard does not adequately consider the unintended consequences of mandatory health checks, such as potential workforce shortages and the negative impact on doctor-patient relationship. A greater focus on proactive health management through GPs, without regulatory oversight, would be a more constructive and supportive approach

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

The focus should be on normalising health assessments throughout a doctor's career rather than imposing mandatory checks at a specific age. The Board should support initiatives that encourage all doctors to maintain a GP and engage in regular health discussions without fear of regulatory consequences.

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 proposed supporting documents (Appendix C-1 to C-5) are not entirely clear or relevant. While they aim to standardise the health check process, they risk being too prescriptive and may not account for the individual circumstances of doctors, particularly those who have successfully managed health conditions throughout their careers. Additionally, the documents seem to focus more on regulatory needs rather than enhancing the doctor-patient relationship, which is crucial for effective health management. This could lead to unintended consequences, such as discouraging openness between doctors and their GPs, as well as early retirements due to anxiety over the process. A more flexible, case-by-case approach, guided by the doctor's GP, would be more appropriate

8.2. What changes would improve them?

The proposed supporting documents (Appendix C-1 to C-5) are not fully supported because they do not adequately address the complexities of health assessments, and they remain tied to regulatory oversight. Health assessments, when used correctly, can support doctors' well-being throughout their careers. However, they should be uncoupled from regulatory processes to maintain trust and promote proactive health management.

Several changes would improve the documents:

1. Simplification and Focus: Health checks should target abilities directly related to practising medicine, such as cognitive and physical functions relevant to the role. Broader health indicators like height and weight, and other elements of health unrelated to fitness to practice should be removed if the health check is going to be used as a regulatory tool.
2. Flexibility for GPs: GPs should have greater discretion in determining which tests are appropriate, rather than following a rigid checklist. This flexibility would ensure that assessments are tailored to individual circumstances, promoting a supportive and well-being-focused approach.

3. Education and Training: More resources should be devoted to educating GPs on managing the health of doctor-patients throughout their careers. This would create a proactive health model, enabling doctors to seek advice and support without fear of regulatory repercussions.
4. Confidentiality Emphasis: Emphasising confidentiality will encourage more open discussions between doctors and their GPs, ensuring health concerns are addressed without fear of regulatory intervention. This would strengthen the doctor-GP relationship.
5. Streamlining Cognitive Testing: Cognitive tests should only be used when clinically indicated.

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

The medical history (C-1) seems excessive and not directly relevant to a doctor's ability to practise safely. Elements such as hearing, vision, height, and weight may not necessarily reflect a doctor's competence, particularly if they have adapted to any impairments throughout their career. The requirement for a broad health check is likely to create unnecessary anxiety and could discourage doctors from seeking regular medical care, fearing that minor health issues will be scrutinised by the regulator.

It would be more appropriate to limit the medical history to health issues directly impacting the ability to practise safely, allowing for more nuanced, case-by-case assessments by the doctor’s GP

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

The proposed examinations and tools listed in the examination guide (C-2) are too broad and may not be entirely appropriate. Cognitive tests such as the MOCA or MMSE, while useful in some circumstances, are not designed to evaluate the complexities of medical practice and could produce false positives, leading to unnecessary regulatory actions. Moreover, requiring such tests without clear evidence of impairment could be seen as punitive and may drive experienced doctors into early retirement. It would be more appropriate to allow GPs to use their discretion to apply tests that are relevant to the specific needs and conditions of their patients. Additional training would be required to ensure that all GPs were confident in performing these examinations.

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

Yes, additional education and resources for GPs on managing doctor-patients would be beneficial. Instead of mandatory health checks, the focus should be on supporting GPs in having sensitive and productive discussions with their doctor-patients about health and safe practice. Encouraging GPs to be proactive in helping their patients manage health concerns throughout their careers, without regulatory pressure, would better support the well-being of doctors. Additionally, more training on how to handle doctor-patients with disabilities would ensure that the assessments are fair and not overly focused on physical conditions that do not impact clinical competence.

Suite 207, 69 Christie Street
St. Leonards, NSW 2065
ABN 93 488 047 426
admin@dhas.org.au

Doctors' Health NSW

Submission to the Australian Medical Board
Health Checks for Late Career Doctors
October 2024

Introduction:
Doctors' Health NSW wishes to express both our concerns and recommendations regarding the Australian Medical Board's proposal to introduce mandatory health assessments for doctors aged 70 and older (Options 2 and 3 of the Consultation Regulation Impact Statement OBPR 21-01302). While we acknowledge the importance of patient safety and understand the intent to protect patients, we have significant concerns that the current proposal would not achieve its intended goal of ensuring fitness to practise. Instead, it may have unintended consequences that could undermine both patient care and doctor well-being. In response, we propose a constructive alternative to the status quo that promotes a more evidence-based, supportive approach to managing doctors' health throughout their careers.

Why We Have Expertise to Comment:
Doctors' Health NSW (DHNSW) is an independent, not-for-profit organisation that supports the health and well-being of doctors and medical students in New South Wales. We provide confidential advice, support, and educational resources aimed at promoting doctors' physical and mental health throughout their careers. Our work ensures that doctors remain healthy, which is crucial to delivering high-quality patient care.

DHNSW has a deep understanding of the challenges doctors face, particularly in the later stages of their careers. We routinely assist doctors in managing their health, stress, and work environments, giving us first-hand insight into how these factors affect their ability to practise safely. Through our confidential support services, we also recognise doctors' concerns about mandatory health checks and the fear of regulatory consequences that may discourage them from seeking help. Given our role and experience, DHNSW is well-placed to provide informed commentary on policies affecting doctors' health and well-being.

Concerns About the Current Proposal:
The proposal to introduce a mandatory health assessment for doctors over 70 oversimplifies the complex issues surrounding fitness to practise by relying solely on age as a trigger for assessment. This approach fails to recognise that age alone is not a reliable indicator of impairment or reduced performance. Medical competence involves a range of skills, including clinical judgement and decision-making, which cannot be adequately evaluated through a standard health assessment or basic cognitive tests.

Furthermore, targeting late-career doctors as the sole group requiring increased scrutiny is not supported by reliable evidence. An increased number of notifications is not a valid measure of decreased fitness to practise, and external factors such as stress and challenging work environments may contribute to higher notification rates for doctors in senior positions, particularly in rural areas. By focusing on age, the proposal risks reinforcing ageism and overlooks the broader context of medical practice.

The idea that all late-career doctors could access a detailed health assessment of their fitness to practise by a specialist occupational and environmental physician (Option 2) is unrealistic in light of the number of practitioners required to complete these assessments. The cost would also be prohibitive.

There is a lack of independent evidence to indicate that the introduction of the proposed mandatory health checks (Option 3) will prevent harm or reduce the number of doctors working while impaired. Without sound evidence to support the proposal, it is feared that introducing general health checks as a proxy measure for fitness to practise may ultimately cause more harm than good.

Suite 207, 69 Christie Street
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admin@dhas.org.au

Doctors' Health NSW

Impact on Individual Doctors:
At a stage in life when doctors are likely to need a strong, confidential therapeutic relationship with their General Practitioner (GP), the proposed mandatory health checks may discourage them from seeking necessary medical help. The fear of regulatory consequences could prevent doctors from openly discussing health concerns with their GP, even over many decades prior to the regulatory assessment, eroding the benefits of a safe and trusted environment for managing their health.

The proposal includes a very broad health check, which encompasses elements that have no obvious relevance to fitness to practise. This is likely to further alarm doctors, making them hesitant to disclose even minor health concerns for fear that such disclosures will be included in a regulatory process.

Mandatory health checks for doctors over 70 are likely to provoke unnecessary stress and anxiety, particularly when they include cognitive tests, which may be seen as punitive or stigmatising. Requiring cognitive testing, such as the MMSE or MOCA, implies decreased fitness to practise based solely on age, which is not evidence-based and is likely to feel demeaning to experienced practitioners. Their public association with potential cognitive decline carries societal stigma, potentially damaging their personal and professional reputations. The process feels punitive, invoking fear of negative outcomes, such as forced retirement or reduced duties.

Basic cognitive tests such as the MMSE or MOCA are insufficient for assessing a doctor's overall fitness to practise. These tests primarily measure general cognitive function and are not designed to capture the complexities of medical practice. While they may detect signs of cognitive impairment, they do not assess critical skills required for effective medical care, such as clinical judgement, decision-making, and problem-solving abilities. Cognitive tests can also produce false positives due to factors like stress or anxiety, leading to unnecessary regulatory action. Furthermore, these tests do not account for a doctor's experience, adaptability, or the support systems they may have in place to compensate for minor cognitive changes. There is insufficient evidence that such tests improve patient outcomes or reduce harm, making them an inadequate tool for assessing fitness to practise.

Impact on the Medical Workforce:
The medical workforce is likely to suffer from the premature loss of experienced practitioners as a result of the implementation of this proposal. Older doctors often play pivotal roles in maintaining continuity of care, particularly in rural and remote areas, while also providing mentorship to junior colleagues. Losing these valuable practitioners could weaken the overall healthcare system and create service gaps, especially in under-served regions.

The proposal also introduces an added burden on the practitioners charged with performing these assessments, many of whom are already facing significant workforce pressures. The potential for a large cohort of senior, experienced doctors to leave the workforce early would exacerbate the existing shortages and ultimately have a negative impact on access to healthcare for large numbers of patients this proposal is intended to protect.

Cost and Practicality Concerns:
The proposed health checks present additional cost and practicality concerns. Occupational health assessments (Option 2), particularly those that include cognitive tests, are more complex and time-consuming than routine health checks. Without Medicare rebates, the financial burden would fall on doctors. It is unlikely that sufficient specialist practitioners would be available to ensure that these assessments can be completed in a timely manner for this large cohort requiring testing.

If Option 3 were selected, many GPs may not have the requisite training or resources to conduct these assessments, adding further complexity and cost.

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A Positive Alternative – Normalising Health Checks Throughout a Doctor's Career:
Rather than implementing age-specific mandatory checks, we propose a model that integrates regular health assessments throughout a doctor's career. These assessments would occur within the confidential GP-patient relationship, encouraging proactive health management without regulatory stigma. By normalising health checks for all doctors, regardless of age, this approach fosters a culture of self-care and peer support throughout the profession.

This alternative reduces the stress of age-based checks while ensuring that health concerns are addressed in a supportive, confidential environment. It follows the evidence that healthier doctors provide better care to their patients, at all stages of their career. Regular follow-ups between assessments would ensure that any health issues are managed effectively, allowing doctors to continue practising safely.

Suggested Approach:

1. **Encourage Regular Health Assessments for All Doctors:**
   Implement confidential health assessments at intervals throughout a doctor's career, by normalising this as a requirement of professionalism and Good Medical Practice. Doctors at all stages of life would benefit from a review within the context of a normal "check-up" with their chosen GP, without the requirement for a formal report to the regulator. Doctors could simply be asked to indicate that this had occurred as part of the annual disclosure. This ensures doctors feel supported in managing their health without fear of regulatory consequences. Normal notification processes would apply if a treating GP had concerns about impairment and patient safety.

2. **Regular GP Follow-up:**
   Between assessments, all doctors should be encouraged to maintain regular check-ups with their GP. This fosters early identification and management of health issues, promoting long-term well-being and professional longevity.

3. **Mentorship and Advisory Roles for Older Doctors:**
   Provide education and encouragement for older doctors to transition into mentorship or advisory roles, allowing them to contribute expertise while managing their workload and health as they age.

Conclusion:
While we recognise the Medical Board's commitment to patient safety, mandatory health assessments for doctors over 70 could lead to unintended and harmful outcomes. A more inclusive, supportive approach—normalising health checks across a doctor's career—would be more effective in promoting doctor well-being and patient safety. Embedding these checks within the trusted GP-patient relationship ensures that doctors can manage their health proactively without fear of negative regulatory consequences.

We urge the Medical Board to consider this alternative, which offers a positive, constructive way to support doctors throughout their careers while safeguarding patient care.

Doctors' Health NSW