AHPRA statistics shows an increase in patient complaints against late career doctors. “Complaints’ are used as a surrogate marker for ‘incompetence’ of late career practitioners as a group and that there is the need to prevent patient harm. It is interesting to note that whilst there is increased regulatory action in 23.2% of late career doctors compared with 13.8% of doctors less than 70 years of age, no late career doctors’ registration was suspended in the study period. The aviation industry does routinely subject pilots to health testing and more recently has introduced competency testing. Competency of medical practitioners is currently not tested in Australia. Competency is assumed after passing an exit exam and normal health is also assumed for all doctors. The introduction of health and or skill testing for late career doctors would be a turning point in the current status quo. It would also be a major leap in a system that does not currently test any medical practitioner for competency. Whilst it may argued that definitive cognitive impairment will result in incompetence, the link between reduced mental capacity and competence is likely to be unclear in a good proportion of late career doctors. There is evidence that late career doctors bring in a range of skills that are not routinely tested eg: wisdom, decision making, judgement- to name a few.

AHPRA intends to prevent patient harm in a ‘*practical*’ and ‘*effective*’ manner.

a) An ‘*effective*’ approach will require addressing the ‘incompetence’ due to underlying issue of reduced critical thinking, cognitive competence, clinical decision making, communication and specialist skills. In other words, a test close to the exit exam by the specialist college. This will require input from the professional peak body and incurs costs and may be potentially onerous- in other words, this will not be ‘*practical*’.
b) A practical solution should not be onerous, time consuming or expensive. For example, a visit to the GP (Option 3) is not onerous. It includes physical health tests and cognitive testing would serve part of the requirements for an effective result. However a GP visit may not address the requirement of critical thinking and testing knowledge of medication, specialist skills and communication skills- in other words, this may not be ‘effective’.

Option 1: The current status quo is perhaps not aligned with safe medical practice. This approach may result in the public perception that the current system is disinterested in

reducing patient harm. However there is no evidence that there is a widespread discontent from the public expect from the increased complaints as per AHPRA. Also, there is currently no recertification of medical practitioners in Australia that tests upto date knowledge and skill requirement for safe practice.

Option 2: The relevance of Option 2 (extensive and detailed 'fitness to practise' assessment by specialist Occupational physicians) suggests that there are detailed evaluation on cognition and this is also skills specific. The mentally sharp late career doctor (about 50%) may be disillusioned from such a proposition and completely retire from the workforce. This is be a lost opportunity of about half of the 5-6% of the current late career doctor work force. The other half may be deemed unsuitable via this test. Therefore there is a high risk that healthcare will lose a high proportion of late career rural radiologists and others practitioners. This will result in worsening the already dire shortage of rural medical practitioners.

Option 3: The 3 yearly GP visit (between 70- 80 years and annually beyond 80 years), is not onerous. This does fulfill health testing requirement but does not address a specific skills requirement. Therefore this does not fulfill the requirement for competence.

Options 2 and 3 may be modified to meet specific requirements eg: testing for critical thinking, cognitive competence and specialist skill specific testing. It is also important to test the physical and mental health of the late career practitioner. Such an approach might include the following two components:

1. GP visit - covers the basics of physical and cognitive / mental health.
2. Specific CPD by the Specialist Professional Peak Body - for critical thinking, clinical communication and specialist specific knowledge, skill and competence.

Statistically it is said that about 50% of more than 70 year olds are mentally sharp. It is possible that this proposal probably applies to the other 50% of late career doctors and may be burden for a substantial proportion of practitioners who feel they are being subject to unnecessary testing not to mention the associated costs that would be charged by the peak body for such a test. Cost offset by a government subsidy to the examining authority is a consideration.

Summary:

1. Physical and Cognitive Testing of late career doctors appears inevitable - in the interests of both practitioner and patient safety.
2. Competence of late career doctors is the issue however this is not being assured by any of the proposed options. In fact, competency testing is not in use for any medical practitioner in Australia. Recertification is the closest avenue however this is not the subject of the discussion.
3. Prescribed peak body CPD as a learning and testing tool is an option and this may be integrated into the current CPD requirements without a significant fall out.
4. One possible combination is a) GP visit and Prescribed CPD once in 3 years for >70 to 79 year olds; b) annual GP visit and Prescribed CPD once in 3 years for 80 years and above. This may be a bridging option until recertification or competency testing of all medical practitioners is introduced.