Comments on APHRA proposed health checks on late career doctors

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These are my preliminary thoughts for discussion. They are based on over 30 years of experience in developing medical standards for safety critical workers.

1. **The problem**. APHRA (medical board) has identified a rapid rise in notifications regarding doctors older than 70 years. It proposes a medical solution in the form of health checks and yet to be defined cognitive assessments.

   The notifications are broadly grouped and until more refined it is difficult to see either where a medical solution would be appropriate and/or what sort of medical assessment would be appropriate and/or how a criteria for pass/fail would be set. (I am aware of a recent case in which a doctor was notified to WorkSafe because he had asked about a person's country of origin and this was alleged by the patient to show racial prejudice. It is not at all clear how a medical examination would prevent this notification).

   Setting of any medical standards is crucially dependent on defining the Inherent Requirements of the job. This is enormously diverse for the various craft groups within medicine. This would make either for a large range of examinations or a shot gun approach which is non-specific.

2. **Evidence of benefits**. There is little evidence that age based examinations for safety critical work are useful. The best example in Australia is regarding age based examinations for holding a driving license. New South Wales requires examination of drivers by their GP at age 80 and over whereas Victoria does not. A careful examination of driving accident rates by Monash University Accident Research Centre found no difference between the two states. (. Langford J, Bohensky M, Koppel S, Newstead S. Do age-based mandatory assessments reduce older drivers' risk to other road users? Accid Anal Prev. 2008 Nov;40(6):1913-8.)

   The discussion paper cites various countries which require examination of doctors over certain ages but gives no evidence that these examinations are beneficial.

3. **A better approach**. Given that there has been a large amount of work in recent years by Colleges and Fellows to develop CPD as a means of ensuring good practice this would be a logical base on which to build. Fellows who do not maintain adequate CPD or for whom a notification is made could then be referred, on a case-by-case basis, for an appropriate medical examination.

   If CPD is not working in this regard it raises a major question of why we are all subjected to CPD?

   P36 "More recently, the Board has required professionalism and ethical behaviour to be embedded in CPD programs, which can include CPD about healthy ageing. Additionally, some professional indemnity insurance providers provide information about doctors' health and premium discounts for completing health assessments. **These approaches do not appear to have made significant differences to the distribution or content of notifications about late career doctors that the Board receives**".

4. **Implementation.**
   Each of the proposed options has problems.

   - Assessment by a specialist. Assessments by FFOEM is absurd: there are only 300 registered Fellows and it is doubtful that even a fraction would wish to do this work. Moreover, no safety critical work examination is based on Specialist recognition alone but requires completion of an approved course to become an Authorised Health Practitioner for that safety critical work. This could include other doctors who wish to undertake such training.
   - As mentioned above the lack of clear definition of inherent requirements and of pass/fail medical criteria would leave open the possibility of complaints to disability discrimination and other forum.
   - Expecting a doctors own GP to perform an assessment which is not simply for general health but for fitness to practice places the GP in a conflict-of-interest situation. This has been studiously avoided in other safety critical work standards. (On the other hand it is strongly encouraged that every doctor has their own GP and should consider the NHS funded health check at age 70).
   - Assessment of cognitive function is central to this proposal but, as correctly identified in the discussion paper, there is no agreement on which, if any, tests have adequate sensitivity and specificity relevant to medical practice.
   - Payment. There are estimates that the fee for an examination by a specialist would be $1500 – $2500. This would be incurred yearly for doctors over the age of 80 and every three years for doctors over 70 years. It appears from the discussion paper that this is to be paid for by the doctor him/herself not APHRA. This is not likely to encourage acceptance of the proposed regime within the profession. (As noted above this is an occupational examination and therefore not relatable under NHS).
   - Privacy. The proposal that the examination covers all the major systems of the body violates privacy with regard to fitness for duty examinations. For example, regarding “genitourinary”, what does a doctor’s sex life or frequency of urination have to do with capacity for good medical practice? Such questions violate privacy.