Your details

Name: [redacted]

Organisation (if applicable): [redacted]

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- ☐ No, do not publish my submission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?

NOT This is blatant discrimination using the blunt instrument of age.

All Doctors should have their own General Practitioner and recommend an annual health check.

Such a health check, as for anyone else, should consider fitness to continue in their current work. Such assessments may, or may not include a mental capacity check. This is the same as getting imaging studies or other investigations and will depend on the clinical presentation at the time.

We do not want to add unnecessary burdens to a stretched health services.

Cognitive capacity screening (if the issue for the Board is cognition, not age) needs specific training. The Mini Mental Status Examination is widely used to assess dementia, but does not pick early stages of the disease. The Montreal Cognitive Assessment may be somewhat better but needs specific training. Who will pay the costs for these assessments, most of which will inevitably be negative for cognitive decline? They should be used when there is a clinical indication for their use, but not otherwise.

Neuropsychology services are expensive, time consuming and limited. They should be used when there is a clinical indication, but not otherwise squandered. Doctors would not be likely to take kindly to a general view that to practice they should be vetted by another professional group.

The Board could as well suggest every medical practitioner have an annual MRI of their brain to assess any possible loss of cortical matter. At what cost? What a denial of service for others by this exercise in an already stretched health system.

There **should not be specific health checks for Doctors on the basis of age,** just as there are not for politicians, or anyone else in the community.

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?

Why not from the outset of practice? This would add another layer of burdensome compliance for practitioners. It would also be a very blunt instrument with no data for effective outcomes from its implementation.

Why for Doctors?

If there are more issues arising from an older cohort of practitioners, are there any data that will be changed by an annual health check?

Are there any other qualities regarding practice that make older practitioners less competent, so that there may be different issues for different areas of practice.

I recall an era overseas when women were discouraged (effectively banned) from orthopedics “as they did not have the strength” – clearly not true and quite discriminatory.

Rather than a blanket discriminatory approach the Board should show more finesse and:

- **Support a culture of self-awareness and good personal health throughout every year of practice.**
- **This should include each doctor being encouraged to have an annual health check with their General Practitioner, who should investigate and advise on the clinical presentation at the time.**

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.

None are desirable. Though option 3 is the least offensive.

Remember also that population health is improving. People are living longer, and doing so in better health than in the past. That includes better health in which to continue their careers. It adds another burden to a workforce where there is already a shortage.

People who previously would have retired at 50, or 60 years of age may now be living and working much longer and in better health than in the past. We are not immortal and obviously, but sadly, some die or become ill and incapacitated for practice when young.

If there is to be any change in practice requirements then the Board has a duty to provide in advance the scientific evidence that the proposed changes have been shown to change the outcomes in the desired direction. The Board should not implement such requirements without scientific support.

If there is to be a trial of such compulsory screening based on age, then it should be for a time limited period. There should be an independent scientific assessment of the outcome, and then a determination that the intervention is effective in changing the outcome, or the requirement for such testing should be ceased at once.

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. As detailed above.

One could equally argue for a detailed cardiac, pulmonary, renal, endocrinology, neurology, orthopedic etc. review.

This is a blunt instrument.

Where are the board data that such assessments will produce the desired outcome?

The Board is proposing unwarranted intrusion into the personal life of Doctors

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 andas they do now, declare whether they have an impairment that may detrimentally affect their ability to practise medicine safely.

The individual medical data should remain confidential.

There is a requirement already to declare impairment. Why does the Board think that having health checks on older practitioners will change that reporting? It is adding a burden to the health system, but if impairments are not reported will not change anything.

Why not **focus on a culture change** (if needed) for each Doctor to care for their health and have an annual health check.

If needed there could be education to all practitioners on penalties by the Board for non-declaration of impairment.

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. Heath matters should be personal, private, and matters for the individual Doctor and their treating practitioner, and of no matter to the Board.

As an analogy, the Board should keep out of the Practitioners bedroom.

Impairments to practice should be reported to the Board, and practice modified, or ceased as appropriate.

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

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

Independent Scientific Data to support any proposed change.

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

The Board should look to support a positive culture, with education, and the promotion of the Health of all Medical Practitioners.

The Board should not look to age discriminatory, added compliance and costs, as well as an added burden to limited heath resources as proposed.

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?

Not needed

8.2. What changes would improve them?

None. The Boards approach is fundamentally inappropriate and wrong

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

NA

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

NA

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

Data to show that such checks will improve rates of reporting impairment, and result in the changes the Board seems to be seeking.

The compliance cost to the individual practitioner, the community and Health services does not seem to have been adequately considered.