ANZSVS
Australian and New Zealand Society for Vascular Surgery

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Medical Board Australia
AHPRA
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Health checks for late career doctors
Consultation Regulation Impact Statement

The proposed policy for Assessing the health and fitness of Australian doctors over the age of 70 is of great significance to Healthcare in Australia and ongoing workforce. It is certainly desirable to ensure competency of practice so as to ensure the safety and well-being of patients. These arguments are well stated in the **Consultation Regulation Impact Statement** (OIA ref #: OBPR 21-01302).

It is worth consideration of scientific claims of unsatisfactory outcomes and increased frequency of Malpractice claims.

Patient Outcomes: Research on patient outcomes related to a doctor's age is mixed. Some studies suggest that patient outcomes are not significantly affected by the age of the physician, while others have found variations. There are some confounding factors (or biases) which may affect these claims, including the type or complexity of practice, established clinicians may be treating older more comorbid patients, and utilising older technology and practice environments. All may impart significant effects.

Malpractice claims data poorly reflect the effect of ageing. Over a long career the exposure to medical incidents and claims increases, there is potential of biases in case-complexity and biased perceptions by patients and guardians of older practitioners.

Age alone should not be the sole determinant of a doctor's ability to practice, regular measures of competence are already in place for many medical practitioners including audit and CPD. These are currently maintaining high standards of care overall. Here are several points of for consideration before adopting any change:

1. The **existing Code of Conduct** sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community.
2. **Established Patient Safety measures**

   Providers may develop difficulties in providing safe practice for a number of reasons which are not purely age dependent. They may also be temporary afflictions or periods of incapacity due to reversible conditions. This may include physical impairment of eyesight, hearing, dexterity, or slower reaction times as well as clarity of thought and reasoning without cognitive decline. These are all factors that may potentially occur at any age. Current mechanisms including self-reporting, peer review and support, clinical audit, outcomes measures and GP / psychiatrists' assessments are relied upon and currently work well.

3. **Supporting doctors in prolonging their careers safely**

   Many doctors over 70 years possess valuable expertise and continue to provide excellent care. Nuanced health and fitness assessments could identify areas where a doctor might need assistance and could be supportive of ongoing safe practice. For example, if a doctor has minor physical limitations but is otherwise cognitively sharp, adjustments such as a reduced workload, ergonomic equipment, or the delegation of certain tasks to colleagues might be recommended.

   This approach supports aging doctors in continuing their practice in a safe, sustainable manner, while also preserving their invaluable experience in the healthcare system.

4. **Advocating a Culture of well-being in the medical profession**

   An appropriately aligned assessment of the health and fitness of older doctors would promote trust and a culture of well-being within the profession. It sends a message that self-care and ongoing evaluation of one's own abilities are important at every stage of a medical career. This proactive approach may encourage doctors to seek support or transition to different roles, such as mentoring or teaching, when they feel their clinical capacity is diminishing. This can also help prevent burnout, which may be more likely among older professionals facing physical and mental demands in a rapidly changing healthcare environment.

In clinical practice, some attributes may help to compensate for slight deterioration in physical and cognitive function and other adaptations may be employed:

1. **Experience and Knowledge**

   Older doctors often have more experience and accumulated knowledge, which can contribute to better diagnostic skills and clinical judgment. Experience allows for a deeper understanding of medical conditions and treatment options.

2. **Cognitive Function and adaptation**

   Age can certainly affect cognitive function but so do many medical conditions. Some studies suggest that while cognitive abilities may decline with age, experienced physicians may compensate for this decline through their extensive knowledge and practical experience.

3. **Adaptability and Learning**

   The ability to adapt to new technologies and medical practices can vary with age. Younger doctors may adapt technologies and techniques, while older doctors might need to put extra effort into staying updated.

4. **Physical and Emotional Stamina**

   Physical stamina and emotional resilience can also be factors. Long hours and the stress of medical practice can impact performance, and this might vary with age. Some doctors may reduce hours to counter potential fatigue.

5. **Maintaining Professional Standards**

   Medicine is a fast-evolving field that requires up-to-date knowledge, critical thinking, and the ability to manage complex cases. Doctors over 70 may have decades of experience, but they may not embrace new treatments or technologies. When supported through continued education and a supportive work environment it is possible to foster the adoption of evolving technologies and extended knowledge base – essential in maintaining high performance at any age.

In response to the Medical Board's three options for consideration to ensure the health of doctors aged 70 years and older. Those being:

1. **Rely on existing guidance (Status quo) .**

   - This is a trusted system with existing quality measures and support mechanisms.
   - This is accepted by the profession and Board but may not be as well-perceived by the public as it should be.
   - This has acceptable cost and time implications for the individual practitioners and the system.

2. **Require a detailed health assessment of the 'fitness to practise' of doctors aged 70 years and older.**

   - This is potentially the least biased and most refined and adaptable approach.
   - The details of such health assessments, however, are currently not well-defined or described. Each aspect of the prescribed tests would need to be supported by high-level evidence (before introduction).
   - The new system would need its governance to ensure quality, relevance, outcome measures, surveys of clinicians' acceptance and an appeals / complaints process.
   - An appropriately designed and governed formal process of assessment and credentialling would establish trust among patients, administrators, doctors and other health-care workers.
   - The testing could be burdensome, time-consuming and costly. It may require clinicians to travel for assessments and lose time away from work.
   - These costs should be borne by the jurisdictions in which the practitioners work. A "user pays" system could potentially result in cost blow-outs for doctors facing a brace of complex tests. Testing for these purposes is "non-clinical" and would not be eligible for medicare rebates, thereby potentially increasing cost to practitioners.
   - This may frustrate some competent doctors and may be the trigger which drives them into early retirement.

3. **Require a general health check for late career doctors.**

   - This would entail a potentially non-standardised health assessment.
   - This is adaptable and likely to involve "common sense" principles. e.g. Providing support for a low acuity role involving reduced hours, working as a medical administrator, medical educator or as a "surgical assistant" – roles that are typical for clinicians "winding down from practice".
   - This is potentially biased as assessments may be undertaken by colleagues or associates. It may place pressure on the colleague acting as assessor.

- This system would rely on the Assessor (Doctor) accepting some accountability for their assessment findings and report. This may expose them to some liability for adverse outcomes as a result of their findings.
- This would engender increased trust for society and the healthcare system (above existing levels).
- This testing would be less burdensome and time-consuming.
- The costs should still be borne by the jurisdictions as these consultations and testing for these purposes is considered "non-clinical" and would not be eligible for medicare rebates.
- This would prove less frustrating to doctors.

Conclusion

The proposed health and fitness assessments for doctors over the age of 70 in Australia are aimed at helping to identify potential deficits that might reduce clinician performance and compromise patient safety.

Australia has existing high standards of patient care. While these can be maintained with existing measures it is important to preserve public trust in the healthcare system. A broadly implemented, standardised testing process would avoid allegations of ageism or discrimination. These assessments will also positively encourage doctors to remain healthy and physically fit, in order to support their continuing careers in a sustainable way.

Any new assessment process, however, will require detailed analysis and careful planning. The health assessment process may be prone to biases unless a standardised, non-discriminatory approach is defined. Nuanced health and fitness assessments should allow for adaptations like adjusting workload, offering support, or working towards retirement when appropriate. Ultimately, the costs for this assessment should be borne by the public (who stand to benefit from maintenance of a capable workforce) and not the individual medical practitioners.

Yours sincerely,

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