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Dr. Joanna Flynn AM

Chair,
Medical Board of Australia
Chair
G.P.O. Box 9958
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Dear Dr Flynn,

Many thanks for the opportunity to provide feedback on the Board's consultation, "Health checks for late career doctors".

I appreciate the good intention of the Board in proposing this new direction for late-career doctors. I have concerns about some of the proposals in the consultation paper.

My over-riding recommendation is that Board should shape a form of registration to utilise the experience, skills and knowledge of late career doctors.

A cautious approach

"The Board is responsible for keeping the public safe by ensuring that only health practitioners who are suitably trained and qualified to practise are registered, and by developing codes and guidelines to guide the profession."

The Board sees its role, properly, as ensuring that medical practice is conducted safely.

It is concerned with people who\ have already been captured within the health care system. There is a wider responsibility of government, that the Board's policies should embrace, which is to be concerned for the people unable to access health care, or, for those rejected or not accepted for health care.

There are defined communities whose access to any level of health care depends on the presence of late career doctors – rural and remote areas, marginalised communities of the homeless, addicted, mental ill, those with coexisting disorders, asylum seekers and refugees, those in contact with the criminal justice system, and other undocumented and excluded people.

It is important to recognise the skills and knowledge that late career doctors bring to the practice of medicine. There is a risk that the Board's actions could narrow the contribution of medical practice to the community.

Positive ageing

Ageing is conditioned by accumulated life experiences, exposures and impairments. There are losses and significant gains. John Olsen at 92 painted masterpieces; Michelangelo at 88-89,

worked on plans for the Church of Santa Maria in Rome; and Arthur Rubinstein performed in Carnegie Hall in his late 80s. Men and women in their 80s and 90s can wield power, politically and through wealth. Those who reach old age have experienced lives of extraordinary richness.

Experience brings with it tacit knowledge - learning by doing – succeeding and failing – learning from patients, fellow workers, and from life stories. As grandparents can calm the upheavals in family life, experience can bring equanimity to the hectic and risk-averse environment of modern medicine; a pause button to pay attention.

Senior doctors with well-worn networks and skills can support younger doctors in areas of complex decision-making. Nowhere is this more important than in caring for older people.

Clinical decision making

There is more to evaluating illness and injury than seeing and listening – the signs and symptoms. It involves touch, feelings, smell, movement, emotion, empathy, pain, and distress. Such sensitivities go beyond the capacity of any screening or formal evaluation of cognitive impairment.

In high-performing clinicians, intuition is developed from memorised patterns of association. Not only patterns of knowledge, but patterns of action and sense of acuity. No-one can pretend that is sufficient, preliminary diagnoses and actions must be checked by reflection and hypothesis testing, especially when there is complexity.

The clinician's task includes the ability to communicate with patients and work with members of the healthcare team. The safe doctor takes account of the views and observations of others – mother of the child, carer of the disabled person, spouse of the demented patient. The essence of good clinical medicine is the ability to make decisions which account for the capability of patient, in their environment, and for the patient to be able to accept and act on medical advice and treatment.

Safe practice and cognitive impairment

In Part C: Impact Analysis Questions the Board discusses declining cognitive function and reaches the conclusion that '*the actual levels of cognitive impairment that preclude safe practice have not been determined*'. In this section, the Board's analysis implies that speed of mental processing is a factor in cognitive decline. No doubt there is a slowing with age. However, taking more time can compensate for slower processing, and can be safe practice. The late career doctor may have difficulty keeping up to date with new biological therapies (as all doctors do), but that can be managed by consulting with colleagues or taking time to look up the relevant literature. Safety could be enhanced in these circumstances.

The Board's consultation paper refers to Alzheimer's disease. The probability that a patient will meet a doctor with this condition is extremely unlikely, a simple calculation from the patterns of incidence.

Ageism

Medicine is not immune from ageism. In *The House of God*, written by a psychiatrist, and based on New York's Beth Israel Hospital, interns use 'gallows humour' as they confront the intractable problems of patients, especially old and complex patients. I have observed similar attitudes and behaviour in Australia. Late career doctors are more likely to be tolerant of the ambiguities of treating complex medical and social problems.

There is a risk of ageism if age only is the determinant of capacity to practise medicine.

Late career doctors have much to offer health care.

Complaints

The simple analysis of complaints by age, leaves many questions answered.

It is likely, because of the nature of practice of late career age doctors, that these doctors are at a higher risk of complaint because of the areas in which they work. They are likely to be less protected than early career doctors. Early career doctors spend substantial parts of their working lives in settings where anonymity and institutional protections operate.

Late career doctors are more likely to be in community practice and to work in areas of ambiguity compared with roles in the hospital system – palliative care, addictions, mental health, co-existing mental health and substance use conditions, corrections, homeless services, sexual health and so on.

The Board's consultation paper makes the point that for two thirds of complaints, no action is taken. Does that mean there is a 'culture of complaint' which needs to be addressed by the Medical Board, and by government?

The incidence of complaints by age is not a sufficient reason to introduce health checks and fitness to practice assessments for late career doctors.

What can older doctors offer?

Knowledge and experience of medical problems, social systems and culture

Late career doctors are more likely to have knowledge and understanding of social and cultural issues.

Community medical practice intersects with the social systems - income, disability, and ageing support. Not only are medical skills needed in this environment, but knowledge of social security, NDIS, aged care and other support systems. Community practice also requires knowledge of statutory and regulatory bodies and the regulations which apply to medical practice and related community actions.

Not infrequently, doctors in the community engage with undocumented persons who are unable to access specific government services. Involvement of this kind is more frequent in non-government organisations, some public sector services, services for asylum seekers, refugees and homeless people. Relationships with Aboriginal and Torres Strait Islander people, and the myriad of peoples from different ethnic and cultural backgrounds that characterise much of Australia, depends on exposure and experience in a range of medical services.

Sensitivity to ethical dilemmas

Most doctors, through their careers, will have been exposed to the ambiguities of managing people with unremitting pain, addictions, mental health, coexisting mental health and substance use conditions, end-of-life decisions, decisions in relation to pregnancy, and termination of pregnancy.

These areas are not well learnt in medical school and grow with time and experience. They are not the problems commonly experienced in hospital residencies. They arise especially in community settings where established guidelines are often deficient.

Chain of care

The missing link in current health systems is continuity of care, something that requires doctors to be involved for sustained periods with population groups; this is more likely to have occurred in late career doctors.

Unusual (novel) situations

The Board's consultation document refers to cognitive function in novel situations. With longer times in practice, novel situations may not be so novel to the older doctor as, during a lifetime of practice, the chances that a doctor will be exposed to unusual (novel) situations will be higher than in younger doctors. It can be argued that late career doctors will be more adept at handling some unusual (novel) situations than less experienced doctors.

Community connectedness

The hospital environment sets limits to clinical exposure so that clinical work focuses on defined body and mental systems. Not so in community practice where problems are undifferentiated, and the pathways are dependent on the resources and services available in the immediate environment.

An important consideration for the Board is that there are GPs who have been working in rural communities or outer urban areas for many years. These doctors will have well-connected relationships to families and individuals, and to the networks servicing those communities. It would be a sad outcome of the Board's actions, if communities were to lose what medical help late career doctors can provide to these communities.

Questions for consideration

The Board is considering three options to ensure doctors get the healthcare they need and are able to keep providing safe care to their patients.

1. Should all registered late career doctors (except those with non-practicing registration) be required to have either a health check or fitness to practice assessment?
   If not, on what evidence do you base your views?

   I agree with the Board's proposal, but not for the reason of the incidence of complaints, but as good practice for ageing persons in general.

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?

   I agree with the plan to commence health checks at the age of 70 years.

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).

   The existing guidance is important as a statement for doctors generally to maintain their health and wellbeing. Medical practice can be stressful and there are reported high levels of burn out. The guidance should continue subject to the option the Board finally adopts.

   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 area of medicine.

   I oppose this option. It is impractical and likely to build another 'health industry' of doubtful social utility, and at great cost. My experience of trying to get detailed cognitive and psycho-neurological assessments in the public sector has been frustrating and unproductive. I doubt the reliability of cognitive assessments in this population group. What's the evidence for validity?

   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.

   I recommend the Board adopt this option. It is practical and implementable and fits with other requirements in ageing persons – for driving, and certain occupational roles. But I have reservations about the level of complexity it will add to the assessing GP and to the late career doctor's roles.

4. Should all registered late career doctors (except those with non-practicing 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?

   In Part C: Impact Analysis Questions the Board discusses declining cognitive function and reaches the conclusion that 'the actual levels of cognitive impairment that preclude safe practice have not been determined'.

   In this section, the Board's analysis implies that speed of mental processing is a factor in cognitive decline. No doubt there is a slowing with age. However, taking more time can compensate for slower processing, and can be safe practice. The late career doctor may have difficulty keeping up to date with new biological therapies (as all doctors do), but that

can be managed by consulting with colleagues or taking time to look up the relevant literature. Safety could be enhanced in these circumstances.

My experience of trying to get detailed cognitive and psycho-neurological assessments in the public sector has been frustrating and unproductive. I doubt the reliability of cognitive assessments in this population group. What's the evidence for validity?

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 practice medicine safely.

   Yes. Health checks/fitness to practice should not be shared with the Board.

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 in health checks/fitness to practice assessments. It is impractical to do so and is far too intrusive.

7. The Board has developed a draft *Registration standard: health checks for late career doctors* that would support option three.

   7.1. Is the content and structure of the draft *Registration standard: health checks for late career doctors* helpful, clear, relevant, and workable?

   Yes.

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

   Yes.

   I am concerned with the definition of impairment as the measure of a late career doctor's function. As with much legislation, and as in this case, there are two aspects which need further elaboration. One is that an impairment may or may not be significant in the context of a doctor's ability to function. It will depend on context and roles – a hospital-based doctor compared to a community doctor; a psychiatrist compared to a surgeon; or, an occupational physician, or public health physician.

   Secondly, impairments, some not significant on their own, may compound with other impairments to reduce functional capacity.

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

8. The Board has developed draft supporting documents and resources to support option three. 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.

8.1. Are the proposed supporting documents and resources (Appendix C-1 to C-5) clear and relevant?

The pre-consultation questionnaire implies a narrow working environment. It is less relevant to doctors working in a wider range of environments than those in private and hospital practice, for example, doctors working in or with NGOs and voluntary organisations, drug and alcohol, mental health, corrections, law enforcement, public health services, private companies – non-profit and profit, and other public or statutory bodies.

8.2. What changes would improve them?

The list of requirements is obviously meant to cover all bases, but they appear over prescriptive. For example, the list of vaccinations – are all doctors expected to have all of these, or some? Similarly, with the blood tests – are they all required? Or is this list to suggest what might be useful?

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

Yes, appropriate.

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

Yes, with reservations about the extent of the medical examination, and, certainly about cognitive impairments. For late career doctors who already have GP the prescriptive approach is probably unnecessary.

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

The Board should anticipate the likely future impact of artificial intelligence (AI).

At one level AI could assist late career doctors in managing the mechanics of practice. The inputs which bombard GPs and specialists could be prioritised allowing more attention to the needs of patients. And AI could trigger prompts and indicators in treatment and increase diagnostic precision.

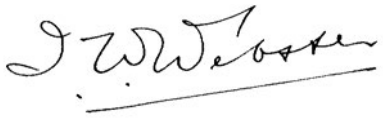
On the other hand, the technology of AI, and the degree to which it is user friendly or unfriendly, could create additional barriers.

Many thanks for inviting responses to the Medical Board's "Health checks for late career doctors".

I wish you well in your deliberations.

I look forward to learning of the outcomes of this work.

Your sincerely,



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