The Board has provided convincing evidence that older doctors are over-represented by complaints. It is now seeking wide consultation on what might be appropriate action to remedy the situation. It is suggesting three options. Thank you for the opportunity to provide feedback.
I will follow the Board's template for feedback but will summarise first my comments.

My summary views are -

A. concerns about doctor health can and should be dealt with adequately by GP assessments, which can be submitted to the Medical Board. GPs do something similar already for driving licences. The requisite frequency of such assessments can be varied to suit different circumstances and concerns
B. concerns about fitness to practice are addressed in part by mandated CPD, which are already submitted to the Medical Board. Cognitive assessments as part of an assessment for fitness to practiice may be indicated in some circumstances but should never be mandated for all doctors
C. registration for doctors over 70 years should be the same as for that of doctors under 70. Discrimination should not occur on the basis of age
D. having only two registration categories - practising v non-practising doctors - is part of the problem. There is a need for at least one other level of registration for doctors who do less. Registration should be based on what doctors choose to do.

A-C) The evidence for <u>more</u> complaints in the over 70+ group is convincing. However, the main evidence presented in Table 1, as opposed to evidence also mentioned in selected papers with ascertainment bias, is not sufficiently granular to draw any sensible conclusions about the action options.

•The three action options that we are asked to consider relate to health status, and fitness to practice.The number of examples of lack of fitness or poor health is not readily apparent from the Types of Notifications Per 1000 Doctors in Table 1. The specific problems of lack of fitness to practice or poor health have not been adequately quantified. (Or they are not shown If they have been quantified).

•The Table does not breakdown complaints by specialty. This could be a critical omission because it makes it difficult to assess the nature of the evidence around complaints. It is quite possible that proceduralists - e.g., obstetricians, cosmetic surgeons, colonoscopists, GPs who perform skin biopsies or deliver babies, surgeons who are not formerly trained at laparascopic surgery - are more likely to be the subject of a complaint.

•On the same theme as the last dot point, there are more complaints about clinical care in the older doctor cohort. This is certainly a concern.

However, the Table does not mention how many of the clinical care complaints were upheld. This is critical information.

Did some of these complaints relate to fashionable patient perceptions of what is best clinical care. E.g., it is not necessarily a bad thing if older doctors perform less investigations, or prescribe less if that indeed was a concern. Medical practice is forever changing and changing back.

•The Table shows that older clinicians are underrepresented with respect to complaints about response to adverse events; overcharging (billing); criminal offences; and breaches of confidentiality. All of these are important matters. Therefore, should younger doctors be assessed differently as a group because they are over-represented in these matters? Of course not. Each of us should be treated the same with respect to credentialing and registration.

Interpretation is fraught without the important information about specialty or procedural breakdown of the doctors subject to complaints, and the number of complaints upheld versus dismissed.

Figure 10, Type of Regulatory Action Taken, is pertinent to this comment. While there were 1.7 x more complaints relating to the over 70 group, there were no fines, reprimands or suspended registrations issued by the Board to this group. Fines, reprimands and suspended registrations, although few, were issued solely to the under 70 doctors group.

D) Two only registration categories is part of the problem. Many older doctors would choose to work less based on their personal competency and energy levels and financial circumstances, but don't because they need to cover costs of registration and insurance.

I would like to see at least one additional level of registration, where the bar for personal doctor health or fitness to practice is not so high. Specifically, why should a non-billing doctor who only maintains professional registration in order to refer himself or herself, or family or friends to practising specialists or to write continuation-only scripts, require the same category of registration as a busy practising doctor who sees public and private patients?

Furthermore, I see no reason for the non-practising doctor registration. What benefit does it confer? I see only the negative of additional cost of registration.

Template feedback

My name is Timothy Florin
I am an Emeritus Professor of Medicine with the University of Queensland
I consent for my comments to be published.

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?* **No.**
2 *If a health check or fitness to practice is introduced..should it commence at 70 or another age?* **No**

All of our population should have regular health checks by a GP or general physician. It would not be unreasonable to require an index (baseline) medical report to be submitted to the Medical Board at the commencement of one's professional career, and stipulate further reports to the Board if there were concerns or at age 70.

Reports to the Board should be brief and could be covered by Medicare. Cognitive assessments as part of assessment of fitness to practice should be undertaken only if indicated by other flags from colleagues or patients. Fitness to practice is already partly assessed by CPD. Mandated additional cognitive assessments would be onerous and in my opinion would not provide value for money. They would most definitely add to costs. As with any assessment or test, there will be false positives and negatives. It is important to avoid adding unnecessary cost to the already inflating cost of registration.

3 *Which options do you agree will provide….?* **Opton 1**
4 *Should all registered practising late career doctors have a cognitive function test..?* **No**

Cognitive function tests should be on an as needed basis and certainly not mandated for all. That would have significant negative and divisive consequences.

Cognitive assessments do not take into account the benefit of experience that comes with attending to many clinical cases.

Cognitive assessments do not take into account the wisdom that comes with age despite cognitive decline.

See my summary views.

5 *Should health checks/ fitness be confidential..?* **Yes**
6 *Do you think the Board should take a more active role…?* **Yes but..**

The Medical Board should act if there is concern but should not initiate a breach of confidentiality. It should have the wisdom not to act where it does little more than expensive meddling.

7 *Comments about what might be missing..?* **Yes please**

There are two categories of registration - that of a practising doctor and that of a non-practising doctor.

I would like to see a category of registration for those doctors who are retired from public consultation in either hospital or rooms, but who may still wish to write referrals to practising doctors (copy to their GP) or prescribe ongoing medication for their family and friends. (I am such a doctor. I also maintain CPD for the purpose of consultation and mentoring in research, the pharmaceutical industry and in legal matters.) I see no reason for the non-practising doctor registration category.