



# Health checks for late career doctors

Consultation Regulation Impact Statement

7 August 2024



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OIA ref #: OBPR 21-01302

**Consultation open from 7 August 2024 to 4 October 2024.**

*Ahpra acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past and present.*

### List of abbreviations

Assessing/treating doctor	Registered medical practitioner who is conducting a health check or providing treatment
Board	Medical Board of Australia
Code	Good medical practice: a code of conduct for doctors in Australia
Doctor/medical practitioner	An individual who is registered by the Medical Board of Australia. This includes practitioners holding provisional, general, limited or specialist registration in any recognised medical specialties or fields of specialty practice that have been approved by the Ministerial Council. It also includes those holding non-practising registration who are not able to practise medicine in Australia
Late career doctors	Registered medical practitioners aged 70 years and older (excluding doctors with non-practising registration)
National Law	Health Practitioner Regulation National Law, as in force in each state and territory
National Scheme	National Registration and Accreditation Scheme
OIA	Office of Impact Analysis

# Contents

<b>PART A: SUMMARY</b>	<b>3</b>
<b>PART B: BACKGROUND</b>	<b>6</b>
<b>Consultation process</b>	<b>7</b>
Questions for consideration	8
<b>Current regulatory environment</b>	<b>10</b>
<b>The medical workforce</b>	<b>12</b>
<b>PART C: IMPACT ANALYSIS QUESTIONS</b>	<b>16</b>
1. What is the problem?	17
2. Why is government action needed?	31
3. What policy options are to be considered?	34
4. What is the likely net benefit of each option?	414
1	
5. Who was consulted and how was their feedback incorporated?	59
6. What is the best option from those considered and how will it be implemented?	63
<b>PART D: APPENDICES</b>	<b>64</b>
Appendix A: Patient and Consumer Health and Safety Impact Statement	65
Appendix B: Option 3 - Proposed registration standard: Health checks for late career doctors	68
Appendix C: Draft documents and resources required for Option 3 - the health check model	72

# **PART A: SUMMARY**

## PART A: SUMMARY

The Medical Board of Australia proposes that late career doctors (aged 70 and older) have regular health checks to support their health and wellbeing and to prevent patient harm.

### Health checks for late career doctors

Early intervention is a key element of good healthcare. By identifying and addressing problems early, we aim to avoid more serious impacts later. This principle underpins the Medical Board of Australia's (the Board) approach to doctors' health. The Board's code of conduct<sup>1</sup> (Code) requires all doctors<sup>2</sup> to have their own general practitioner (GP), to help them take care of their health and wellbeing throughout their working lives. Healthy doctors are the cornerstone of Australia's healthcare system.

However, doctors have a reputation as reluctant patients, and the Board is concerned that doctors do not always seek the care they need. This is a particular issue for late career doctors (those aged 70 years and older), given that health challenges escalate with age. There is also strong evidence that there is a decline in performance and patient outcomes with increasing practitioner age, even when the practitioner is highly experienced.

This Consultation Regulation Impact Statement (CRIS) released by the Board seeks feedback from stakeholders on the effectiveness of current requirements for late career doctors to manage their health, whether additional safeguards are needed and whether late career doctors should be required to have regular health checks so they can make informed decisions about their health and practice and manage the related risk to patients.

The Board has reviewed available research, consulted key stakeholders (including jurisdictions, specialist medical colleges, medical associations, professional indemnity insurance providers and consumers), and considered a range of options. It is now consulting on the following options:

- Option 1 Rely on existing guidance (Status quo).
- Option 2 Require a detailed health assessment of the 'fitness to practise' of doctors aged 70 years and older. 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.

The Board recognises that any process that routinely screens older doctors in Australia needs to balance the responsibility to protect patients from harm from undetected poor performance, with the costs and benefits. It must be fair to all doctors, including those who have no performance concerns, and avoid unnecessary loss of workforce.

This paper:

- considers the Office of Impact Analysis (OIA) *regulatory impact analysis* questions
- outlines the problem the Board is trying to solve
- discusses options that the Board is considering and seeks feedback on these options

<sup>1</sup> Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia [Internet]. Melbourne (AU) MBA, 2020 October [cited 11 April 2024]. Available from: <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>

<sup>2</sup> The terms doctor and medical practitioner are used interchangeably throughout this document.

- provides specific information about how option three would be implemented:
  - a registration standard to support general health checks for late career doctors
  - how the health check process would work
  - the clinical content of the health check
  - resources for the health check, and
  - the evidence for requiring a health check.

# **PART B: BACKGROUND**

## PART B: BACKGROUND

### Consultation process

This paper meets the consultation requirements of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law) and the Australian Government Office of Impact Analysis (OIA) requirements for a Consultation Regulation Impact Statement (CRIS).

This CRIS provides a summary of the Board's assessment of the impact and costs and benefits of options in relation to health checks for late career doctors.

The CRIS is informed by extensive consultation already undertaken by the Board in 2021/22 with both the medical profession and other stakeholders (see p60 for further information). It has been developed in consultation with the OIA. Public consultation with stakeholders and the public on the CRIS will occur for eight weeks and will close on 4 October 2024. Feedback provided from the public consultation will assist in the development and preparation of the final decision RIS (DRIS).

The Board is undertaking consultation to seek feedback from a wide range of stakeholders and the community to help the Board better assess the extent of the problem, the potential impacts of the proposed options and the most appropriate response. The Board considers that any regulatory action needs to be proportionate and balance reasonable requirements for late career doctors to monitor their health and address issues which may affect their capacity to safely provide medical care to their patients.

This paper compares three non-regulatory and regulatory options:

- Option 1 Rely on existing guidance (Status quo).
- Option 2 Require a detailed health assessment of the 'fitness to practise' of doctors aged 70 years and older. 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.

Feedback received from this consultation will be incorporated into the final DRIS that informs the decision whether to proceed with one of the proposed options.



## 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-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?
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?
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.

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?
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 practise medicine safely.
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?
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?
  - 7.2. Is there anything missing that needs to be added to the draft registration standard?
  - 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?
- 8.2. What changes would improve them?
- 8.3. Is the information required in the medical history (C-1) appropriate?
- 8.4. Are the proposed examinations and tools listed in the examination guide (C-2) appropriate?
- 8.5. Are there other resources needed to support the health checks?

Please provide written submissions by email, marked:

‘Consultation – Health checks for late career doctors’

to [medboardconsultation@ahpra.gov.au](mailto:medboardconsultation@ahpra.gov.au) by close of business on 4 October 2024.

Submissions by post should be addressed to the Executive Officer, Medical, Ahpra, GPO Box 9958, Melbourne 3001.

### **Publication of submissions**

The Board publishes submissions on its website at its discretion. In the interests of transparency and to support informed discussion among the community and stakeholders, we generally publish submissions. Please advise us if you do not want your submission published.

We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we will remove personally identifying information from submissions, including contact details.

The views expressed in the submissions are those of the individuals or organisations who submit them, and their publication does not imply any acceptance of, or agreement with, these views by the Board.

The Board accepts submissions made in confidence and will not publish these on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the Freedom of Information Act 1982 (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission or want us to treat all or part of it as confidential.

## Current regulatory environment

Agencies and individuals across the health sector have a shared role in identifying and mitigating risks to public and patient safety. The role of each individual and agency varies, but we share a commitment to ensuring patients in Australia receive safe care.

Health Ministers have governing responsibilities under the National Registration and Accreditation Scheme (the National Scheme) including approving registration standards recommended by National Boards. Governments also have an interest in ensuring that their regulatory frameworks achieve their stated objectives, including through the National Scheme which is founded on the National Law<sup>3</sup> that is applied in each state and territory.

The Board is responsible for helping keep 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.

Medical practitioners are registered nationally under the National Scheme and must comply with the National Law and approved registration standards. They are expected to follow any approved codes and guidelines issued by the Board. The Australian Health Practitioner Regulation Agency (Ahpra) works in partnership with the Board to ensure the community has access to a safe health workforce across all professions registered under the National Scheme.

The Board has approved registration standards for:

- continuing professional development
- professional indemnity insurance
- recency of practice
- criminal history
- English language skills
- limited registration
- general registration
- specialist registration
- endorsement of registration for acupuncture
- endorsement of registration for cosmetic surgery.

Registration standards are regulatory instruments that are recommended by the Board and approved by the Ministerial Council<sup>4</sup> for the National Scheme.

The Board also has a range of codes, guidelines and policies to guide the profession about the Board's expectations. The code of conduct, *Good medical practice: a code of conduct for doctors in Australia*, describes the Board's expectations of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the

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<sup>3</sup> Australian Health Practitioner Regulation Agency. Health Practitioner Regulation National Law Act [Internet] Melbourne (AU): Australian Health Practitioner Regulation Agency; 2023 [updated 2023; cited 2024 June 11]. Available from: <https://www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx>

<sup>4</sup> Australian Government. Health Ministers' Meeting (HMM) [Internet]. Canberra (AU): Department of Health and Aged Care; [updated 24 April 2024; accessed 11 June 2024]. Available from: <https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm> (The Ministerial Council currently meets as Health Ministers' Meeting).

standards of ethical and professional conduct expected of doctors by their professional peers and the community.<sup>5</sup>

The code of conduct makes it clear that it is important for doctors to maintain their own health and wellbeing, which includes having their own general practitioner. It encourages doctors to seek independent, objective advice when they need medical care, and to be aware of the risks of self-diagnosis and self-treatment. When a doctor knows or suspects that they have a health condition or impairment that could adversely affect their clinical judgement or performance, they are advised to not rely on their own assessment of the risk they pose to patients. They are advised to consult their doctor about whether, and in what ways, they may need to modify their practice, and to follow their doctor's advice.

The code of conduct is part of the current regulatory framework that applies to all registered medical practitioners and all areas of medical practice. The broad principles in *Good medical practice* apply to all areas of medical practice and have done so since the start of national regulation in July 2010.

If a patient is dissatisfied with the care they received from a medical practitioner, they may make a complaint to the health complaints entity in their state or territory and/or make a notification (complaint) to the Board. When a notification is made, Ahpra assesses the matter and can investigate.<sup>6</sup> The Board determines whether the practitioner has engaged in unprofessional conduct or unsatisfactory professional performance based on the evidence gathered. Registration standards, codes and guidelines may be used as evidence of what reasonably constitutes appropriate professional conduct or practice.

The Board introduced a [Professional Performance Framework](#) in 2017 to support doctors to provide safe care throughout their working lives. Pillar two of the Framework, Active assurance of safe practice, is shaped by evidence of increasing risk from both doctors' increasing age and from their professional isolation. The Board developed the Framework after advice from an Expert Advisory Group and significant public and stakeholder consultation in 2016/17.

The Professional Performance Framework provides a regulatory framework to support safe practice and is an important element in the Board's approach to managing risk.

The Board is exploring ways to enable doctors to better manage their own health and, in the process, prevent avoidable risks to patients that can arise from unidentified or unaddressed health issues.

The general health checks or fitness to practise assessments for late career doctors would form part of the regulatory framework that supports safe practice and is an important element in the Board's approach to managing risk.

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<sup>5</sup> Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*. Melbourne (AU). MBA; 2020 October [cited 2024 June 11]. Available from: <http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>

<sup>6</sup> Further information about complaints and notifications, including how Ahpra works with health complaints entities and how the processes vary in NSW and Queensland is available at: <http://www.ahpra.gov.au/Notifications.aspx>.

## The medical workforce

Doctors must renew their registration annually to practise medicine in Australia. The National Scheme has robust data that enables us to identify medical practitioners by age.

In June 2023, there were 132,366 doctors registered to practise medicine in Australia and a further 4,376 holding non-practising registration.

Of those registered to practise, 6,975 (5.27%) were aged 70 years and older. 3,854 doctors were aged 70 to 74 years, 2,086 were 75 to 79 years and 1,035 aged 80 years and over.<sup>7, 8</sup> Figure 1 shows the demographics of the medical workforce, and the age distribution of doctors is shown in figure 2.

Around 80% of Australia's late career doctors are actively engaged in the profession, working more than 20 hours per week. Figure 3 shows the number of hours worked by doctors aged over 65 years of age with 15% working less than 20 hours per week, 25% working between 20 and 34 hours per week, and 29% working between 35 and 49 hours per week.

The vast majority of doctors practise in metropolitan areas. Figure 4 shows the geographical distribution of doctors across Australia, using the Modified Monash Model (MMM) and figure 5 shows the distribution of late career doctors, using the same model.

Of the 132,366 doctors holding practising registration in Australia, 80,543 (60.85% of doctors) hold specialist registration - 34,934 (26.39% of doctors) are specialist general practitioners and 8,484 (6.41% of doctors) are specialist surgeons.<sup>7</sup> Figure 6 shows the age distribution of these doctors.

While late career doctors make up a relatively small proportion of the medical workforce, there is an opportunity for the Board to prevent avoidable harm to patients, by ensuring doctors' health concerns are identified and addressed before a decline in their health impacts on their capacity to practise.

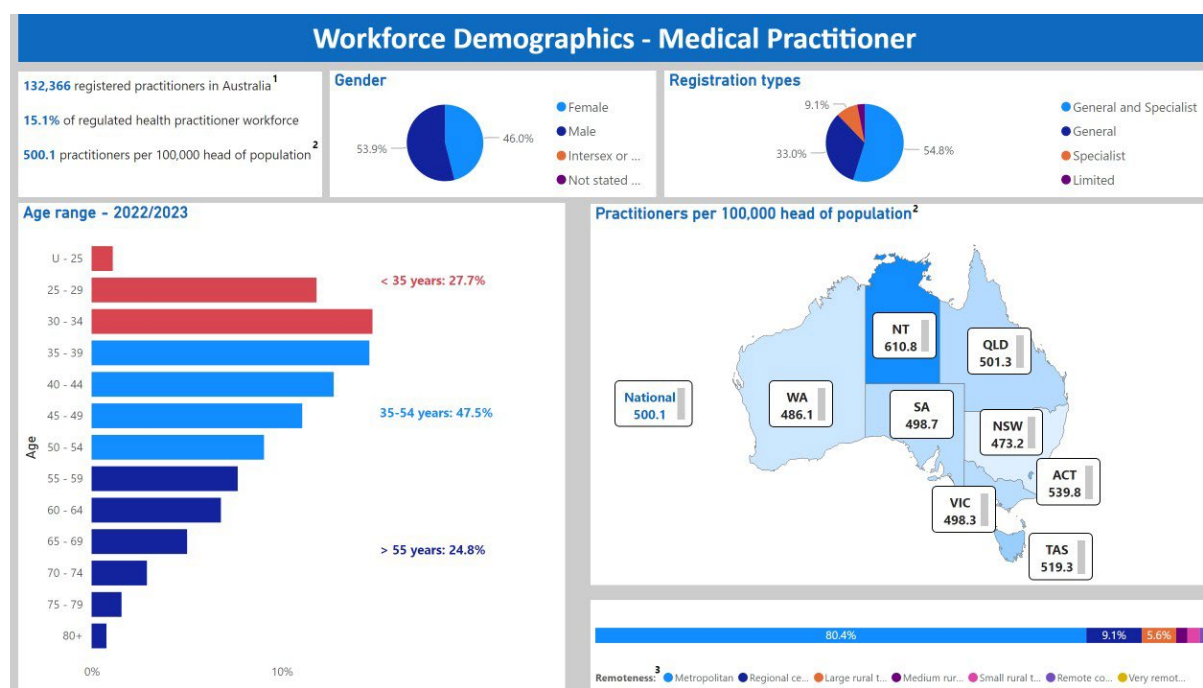


Figure 1: Medical workforce demographics<sup>7</sup>

<sup>7</sup> Medical Board of Australia Registration data June 2023 In: Annual report 2022-2023 [Internet]. Melbourne (AU). Australian Health Practitioner Regulation Agency. 2023 November. [cited 2024 June 11] Available from: <https://www.medicalboard.gov.au/News/Annual-report.aspx>

<sup>8</sup> Medical Board of Australia. Statistics [Internet]. Melbourne (AU) Australian Health Practitioner Agency. 2023 November. [cited 2024 June 11]. Available from: <https://www.medicalboard.gov.au/News/Statistics.aspx>

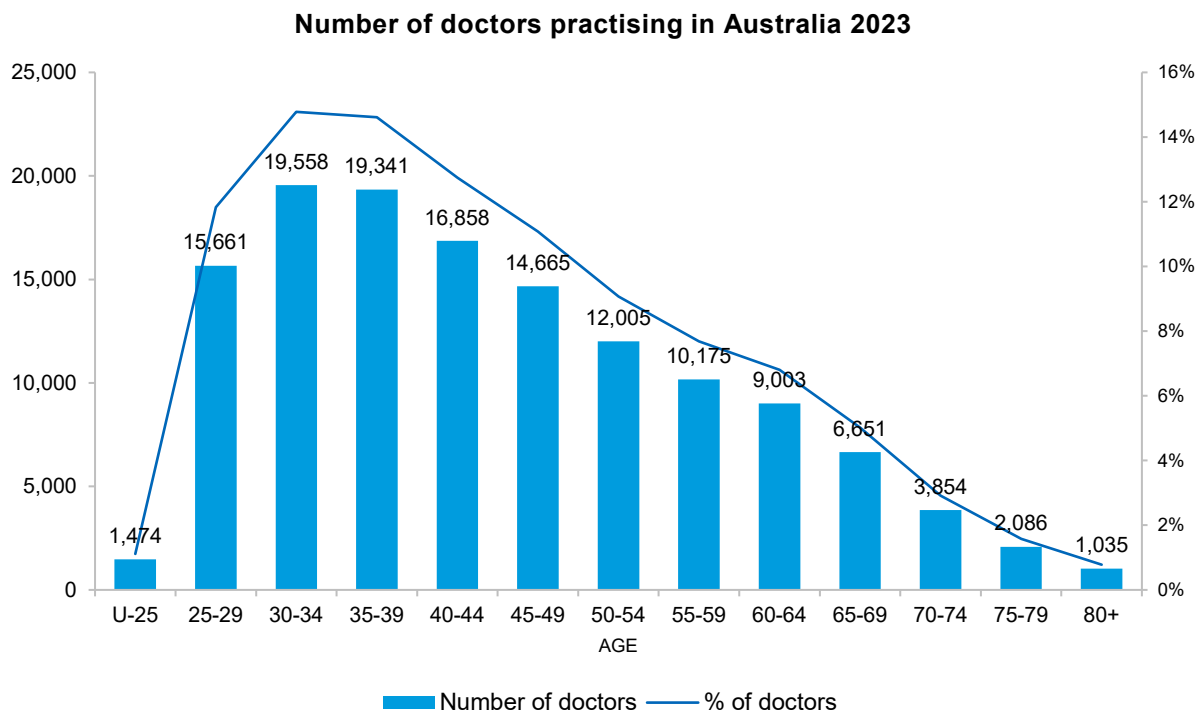


Figure 2: Number of registered doctors June 2023 (excluding non-practising registration)<sup>7</sup>

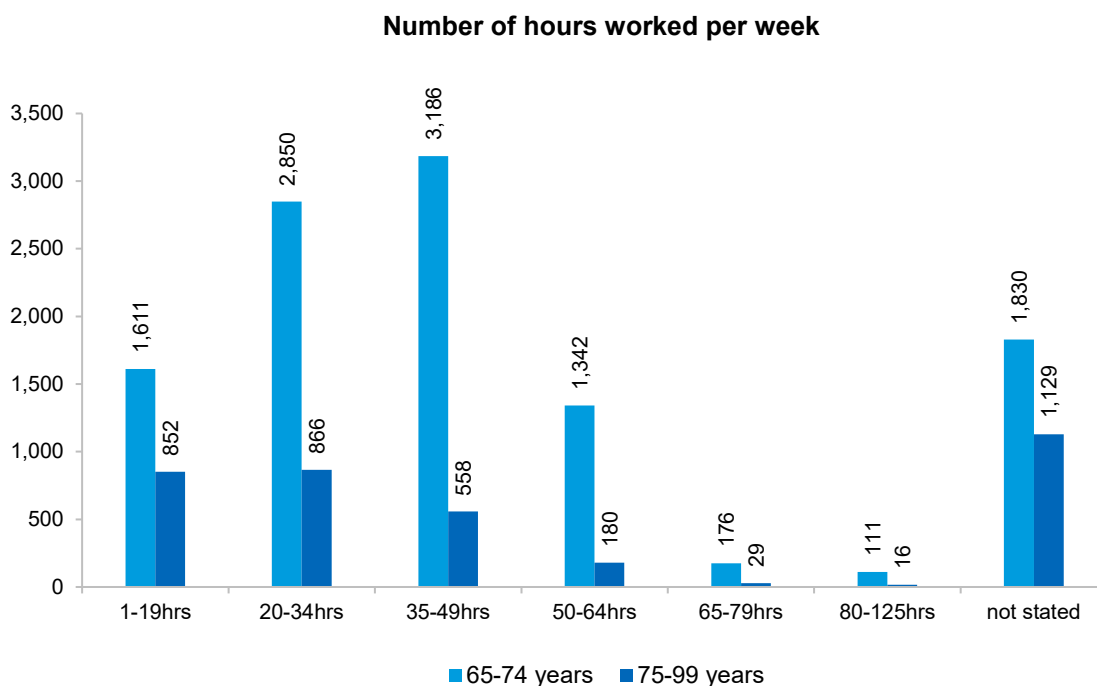


Figure 3: Number of hours worked per week in 2023 – doctors aged 65 and older<sup>9</sup>

<sup>9</sup> Health workforce data 2023 [Internet]. Canberra (AU) Australian Institute of Health and Welfare 2023 [cited 2024 July 10] Available from: <https://hwd.health.gov.au/webapi/jsf/dataCatalogueExplorer.xhtml>

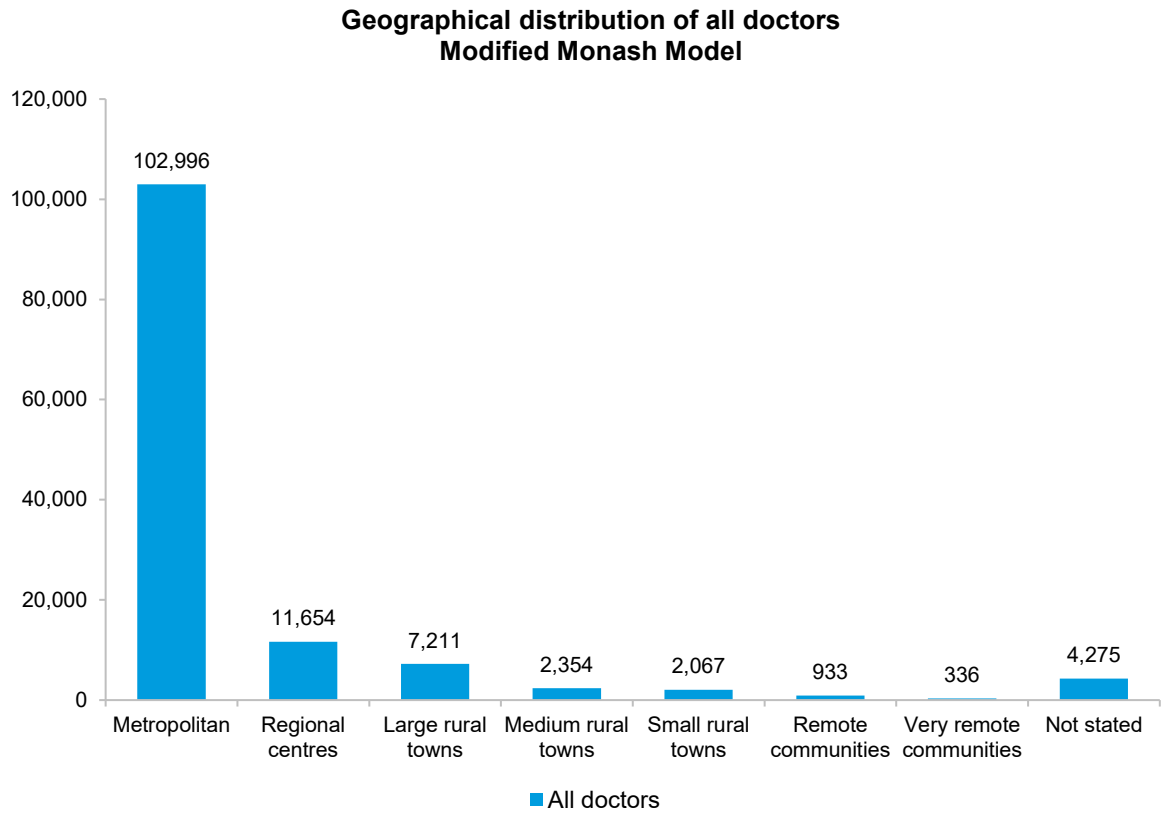


Figure 4: Geographical distribution of doctors across Australia, using the Modified Monash Model (MMM)<sup>7</sup>

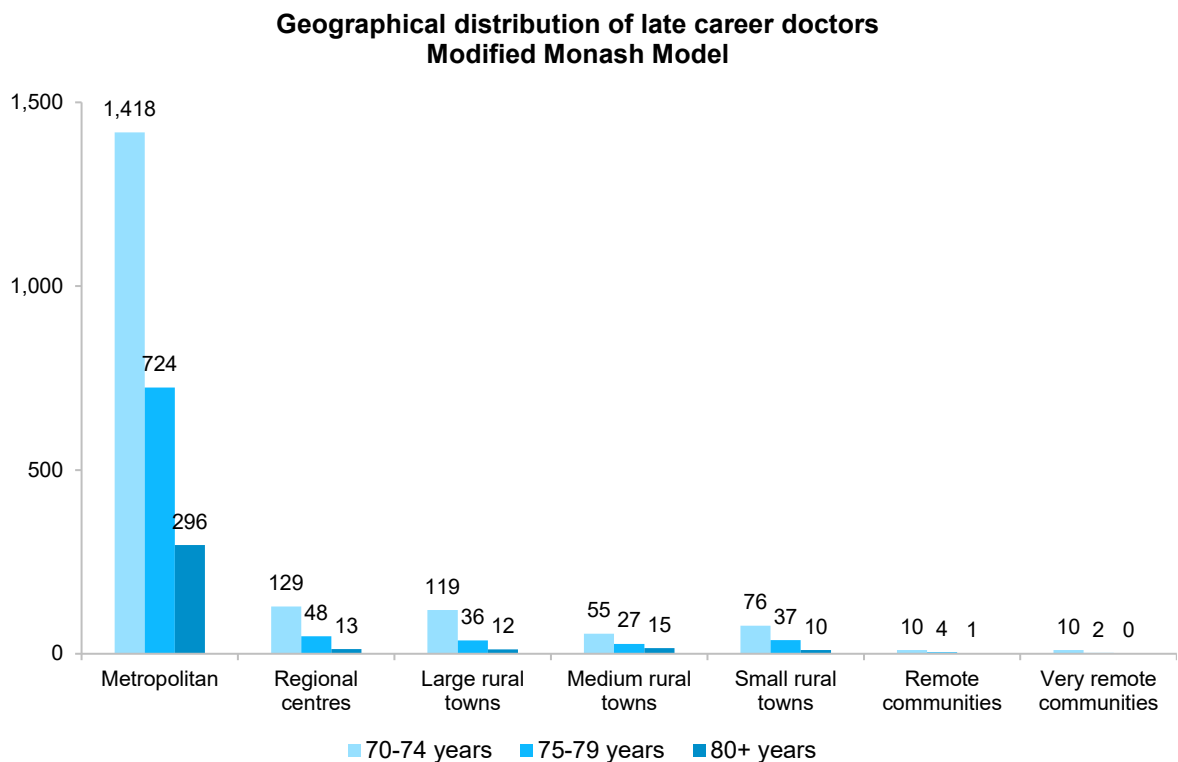


Figure 5: Geographical distribution of late career doctors across Australia, using the Modified Monash Model (MMM)<sup>7</sup>

### Number of doctors, specialists, GPs and surgeons in Australia

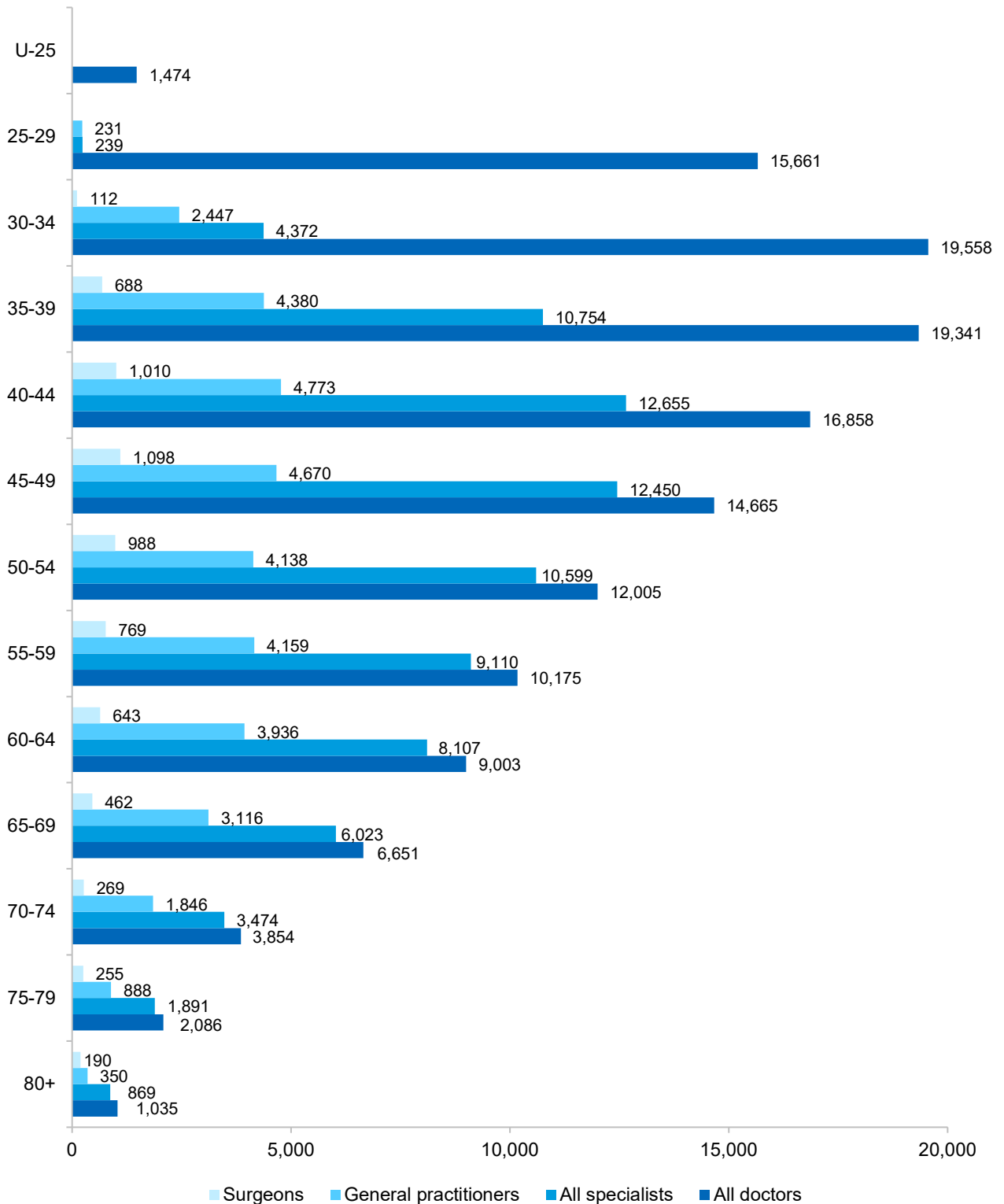


Figure 6: Age distribution of all doctors, specialists, GPs and surgeons in Australia<sup>10</sup>

<sup>10</sup> Medical Board of Australia. Statistics [Internet]. Melbourne (AU) Australian Health Practitioner Agency. 2023 November. [cited 2024 June 11]. Available from: <https://www.medicalboard.gov.au/News/Statistics.aspx>



# **PART C: IMPACT ANALYSIS QUESTIONS**

# PART C: IMPACT ANALYSIS QUESTIONS

## 1. What is the problem?

There is increasing incidence of health concerns as individuals age. The impact of this is greater among medical practitioners, if they have undiagnosed health concerns that could negatively affect their performance and therefore increase risk to patients. Current regulatory measures are failing to detect some practitioners with health issues that are affecting their ability to practise safely. This is increasing the likelihood that individual late career doctors will face regulatory action at the end of their careers.

### Introduction

There is an increased incidence of declining health as individuals age, and this affects medical practitioners in the same proportions as the rest of the community. There is strong evidence that there is a decline in performance and patient outcomes with increasing practitioner age, even when the practitioner is highly experienced.

Late career doctors are also at higher risk of notifications (complaints) relating to physical or cognitive impairment (including memory loss and diminished reasoning), records and reports, prescribing or supply of medicines, disruptive behaviour and treatment. There have been many examples when doctors with previously unblemished careers have experienced a decline in their health and lost insight because of a decline in cognitive executive function, leading to consequences for their patients and the need for regulatory action. The end result of a practitioner with serious health issues who continues to practise medicine is the risk of patient harm.

The community has a right to expect that their doctor's health is not compromised, and they are able to deliver good care. The community expects that Governments, agencies, health providers, the Board and the profession take reasonable steps to identify and manage predictable risks to patient safety. When a medical practitioner has a health concern, the community expects that they will manage it and that it won't impact on the doctor's ability to provide safe care.

### The problem

Doctors have similar rates of chronic illness and have the same preventive health needs as the general community<sup>11,12</sup> and illness and burnout endangers the delivery of high-quality health care<sup>13</sup>. For example, the consequences of burnout go beyond its effect on the doctor and their family – it can lead to medical errors, lower patient satisfaction, longer hospital stays, and even higher mortality.<sup>14</sup> This is a particular issue for late career doctors (defined as doctors aged 70 years and older), given that health challenges escalate with age.

<sup>11</sup> Kay M, Mitchell G, Clavarino A and Doust J. Doctors as patients: a systematic review of doctors' health access and the barriers they experience. *Br J Gen Pract* [Internet] 2008 July [cited 2024 January 17]; 58: 501–508. Available from: <https://bjgp.org/content/bjgp/58/552/501.full.pdf>

<sup>12</sup> Kay, M, Mitchell G, Del Mar CB. Doctors do not adequately look after their own physical health. *MJA* [Internet] 2004 October [cited 2024 January 17]; 181: 368–370. Available from [https://www.mja.com.au/system/files/issues/181\\_07\\_041004/kay10461\\_fm.pdf](https://www.mja.com.au/system/files/issues/181_07_041004/kay10461_fm.pdf)

<sup>13</sup> Sklar D. Fostering Student, Resident, and Faculty Wellness to Produce Healthy Doctors and a Healthy Population. *Acad Med* [Internet] 2016 September [cited 2024 January 17]; 91(9): p1185-1188. Available from [https://journals.lww.com/academicmedicine/fulltext/2016/09000/fostering\\_student\\_resident\\_and\\_faculty\\_wellness.1.aspx](https://journals.lww.com/academicmedicine/fulltext/2016/09000/fostering_student_resident_and_faculty_wellness.1.aspx)

<sup>14</sup> Sinsky CA, Trockel MT, Dyrbye LN, Wang H, Carlasare LE, West CP, Shanafelt TD. Vacation Days Taken, Work During Vacation, and Burnout Among US Physicians. *JAMA Network Open*. [Internet] 2024 January [cited 2024 January 17] 2;7(1): e2351635. Available from: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813914>

Studies suggest that the effect of age on an individual doctor's outcomes is variable but that on average, doctors' ability to provide good medical care to their patients (described in section 3 of the Code<sup>15</sup>) declines with increasing years in medical practice. Ageing is associated with declines in cognition, sensory and motor abilities, knowledge currency, and adherence to standards of care<sup>16</sup> and these age-related changes can affect clinical performance and their ability to provide safe care to patients. Older doctors may not have contemporary clinical knowledge, adhere less often to standards of appropriate treatment, and perform worse on process measures of health care quality in relation to diagnosis, screening, and preventive care.<sup>17</sup> A large study by Tsugawa et al. also found an association of age with reduced patient outcomes (higher 30-day mortality), especially for low-volume practice.<sup>18</sup>

Older doctors represent a valuable asset to the medical profession and some studies have demonstrated that doctors under 65 years can perform at or near the level of their younger peers. Drag et al. found that on computerised tasks, 78% of surgeons between 60 and 64 years of age performed at equivalent standard to younger colleagues, while this dropped to 52% of those 65 to 69 years, 53% of those aged 70 to 74 years and 22% of those 75 and older.<sup>19</sup> Older doctors make a significant clinical workforce contribution, as well as undertaking many essential roles including educating, mentoring and supervising.<sup>20</sup>

The effect of age on any individual doctor's competence can be highly variable and the reasons for this are likely multifactorial.<sup>21</sup> Competence and health, rather than mandatory retirement due to age per se, should be the deciding factors regarding whether doctors should be able to continue to practice.<sup>31</sup> Deterioration in health from any cause should be recognised so that the ramifications can be managed proactively. Difficulties a doctor experiences may also be compounded by hearing or visual impairment and decline in manual dexterity.<sup>22</sup>

While there is an unpredictable trajectory of physical and cognitive decline<sup>23</sup>, physical decline in an individual is often easier to recognise than cognitive impairment which is cumulative and may be less obvious to the affected practitioner.<sup>24</sup> Blasier reported that 'knowledge and experience remain for a

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<sup>15</sup> Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia [Internet]. Melbourne (AU) MBA, 2020 October. [cited 11 April 2024]. Available from: <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>

<sup>16</sup> Sherwood R, Bismark M. The ageing surgeon: a qualitative study of expert opinions on assuring performance and supporting safe career transitions among older surgeons. *BMJ quality & safety* [Internet]. 2020 Feb [cited 2024 April 11]; 29(2):113-21. Available from: <https://qualitysafety.bmj.com/content/29/2/113>

<sup>17</sup> Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Ann Intern Med* [Internet]. 2005 Feb [cited 2024 April 11]; 15;142(4):260-73. Available from: <https://pubmed.ncbi.nlm.nih.gov/15710959/>

<sup>18</sup> Tsugawa Y, Newhouse JP, Zaslavsky AM, Blumenthal DM, Jena AB. Physician age and outcomes in elderly patients in hospital in the US: observational study. *BMJ* [Internet]. 2017 May 16 [cited 2024 April 11]; 357:j1797. Available from: <https://pubmed.ncbi.nlm.nih.gov/28512089/>

<sup>19</sup> Drag LL, Bieliauskas LA, Langenecker SA, Greenfield LJ. Cognitive functioning, retirement status, and age: results from the Cognitive Changes and Retirement among Senior Surgeons study. *J Am Coll Surg* [Internet]. 2010 Sep 1 [cited 2024 April 11]; 211(3):303-7. Available from: <https://pubmed.ncbi.nlm.nih.gov/20800185/>

<sup>20</sup> Wijeratne C, Peisah C. Accepting the challenges of ageing and retirement in ourselves: The need for psychiatrists to adopt a consensus approach. *Aust N Z J Psychiatry* [Internet]. 2013 May [cited 2024 April 11]; 47(5):425-30. Available from: <https://pubmed.ncbi.nlm.nih.gov/23399858/>

<sup>21</sup> Sherwood R, Bismark M. The ageing surgeon: a qualitative study of expert opinions on assuring performance and supporting safe career transitions among older surgeons. *BMJ quality & safety* [Internet]. 2020 Feb 1 [cited 2024 April 11]; 29(2):113-21. Available from: <https://qualitysafety.bmj.com/content/29/2/113>

<sup>22</sup> Schofield DJ, Beard JR. Baby boomer doctors and nurses: demographic change and transitions to retirement. *Med J Aust* [Internet]. 2005 Jul [cited 2024 April 11]; 183(2):80-3. <https://pubmed.ncbi.nlm.nih.gov/16022613/>

<sup>23</sup> Blondell SJ, Hammersley-Mather R, Veerman JL. Does physical activity prevent cognitive decline and dementia?: A systematic review and meta-analysis of longitudinal studies. *BMC public health* [Internet]. 2014 May 27 [cited 2024 April 11]; 14:510. Available from: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-510>

<sup>24</sup> Murman DL. The impact of age on cognition. *Semin Hear* [Internet]. 2015 Aug [cited 2024 April 11]; 36(3):111-21. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4906299/>

long time. First to go is strength, then eyesight, then dexterity, and finally cognition. Knowledge, experience and reputation can compensate for a long time. The declines are gradual.<sup>25</sup>

## Cognition

Ageing practitioners may be affected by different age-related sensory and neurocognitive changes,<sup>26,27</sup> including a decline in processing speed, reduced problem-solving ability and fluid intelligence, impaired hearing and sight, and reduced manual dexterity. This parallels the changes in the general population.<sup>28</sup>

The Australian population is ageing. Between 1999 and 2019, the proportion of the population aged 65 years and over increased from 12.3% to 15.9%. This group is projected to increase more rapidly over the next decade, as further cohorts of baby boomers (those born between the years 1946 and 1964) turn 65.<sup>29</sup> Doctors are part of this ageing population.

The *World Alzheimer's Report 2015* summary shows the regional crude estimate of dementia prevalence in people aged 60 years and older now in Australasia is 6.7%.<sup>30</sup> Dementia is the single greatest cause of disability in Australians aged 65 years or older.<sup>31</sup> Research published by the Alzheimer's Australia indicates that 20% of women over the age of 65 and 17% of men over the age of 65 will develop dementia.<sup>32</sup>

Durning et al. call attention to the importance of both crystallised and fluid intelligence in enabling accurate clinical decision-making by doctors.<sup>33</sup> Adler and Constantinou describe crystallised intelligence as the cumulative information acquired throughout life, which includes professional expertise and wisdom which is usually preserved until well into old age.<sup>34</sup> They describe fluid intelligence as the capacity to process information and reason, which is critical to analysing and solving novel or complex problems, noting that normal cognitive ageing involves a decline in fluid intelligence beginning in the middle adult years, whereas crystallised intelligence tends to remain stable. Numerous cross-sectional studies have shown there is an improvement in crystallised abilities

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<sup>25</sup> Nwanyanwu KM, Nunez-Smith M, Gardner TW, Desai MM. Awareness of diabetic retinopathy: insight from the National Health and Nutrition Examination Survey. *Am J Prev Med* [Internet]. 2021 Dec 1 [cited 2024 April 11]; 61(6):900-9. Available from: <https://pubmed.ncbi.nlm.nih.gov/34426057/>

<sup>26</sup> Eva KW. The aging physician: changes in cognitive processing and their impact on medical practice. *Acad Med* [Internet]. 2002 Oct 1 [cited 2024 Jun 11]; 77(10): S1-6. Available from: [https://journals.lww.com/academicmedicine/fulltext/2002/10001/the\\_aging\\_physician\\_changes\\_in\\_cognitive.2.aspx](https://journals.lww.com/academicmedicine/fulltext/2002/10001/the_aging_physician_changes_in_cognitive.2.aspx)

<sup>27</sup> Redfern N, Gallagher P. The ageing anaesthetist. *Anaesthesia* [Internet]. 2014 Jan [cited 2024 Jun 11]; 69;1:1-5. Available from: <https://pubmed.ncbi.nlm.nih.gov/24320852/>

<sup>28</sup> Skowronski GA, Peisah C. The greying intensivist: ageing and medical practice—everyone's problem. *Med J Aust* [Internet]. 2012 May [cited 2021 Jun 11]; 196(8):505-7. Available from: <https://pubmed.ncbi.nlm.nih.gov/22571306/>

<sup>29</sup> Australian Bureau of Statistics. Australian Demographic Statistics [Internet]. Canberra (ACT): ABS; 2019 Jun [cited 2024 Jun 11]. Available from: [https://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument#:~:text=PEOPLE%20AGED%2065%20YEARS%20AND.1946%20and%201964\)%%20turn%2065](https://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument#:~:text=PEOPLE%20AGED%2065%20YEARS%20AND.1946%20and%201964)%%20turn%2065)

<sup>30</sup> Alzheimer's Disease International. World Alzheimer Report 2015: The global impact of dementia [Internet]. London: ADI; 2015 [cited 2024 Jun 11]. p8. Available from: [www.alz.co.uk/research/worldalzheimerreport2015summary.pdf](http://www.alz.co.uk/research/worldalzheimerreport2015summary.pdf)

<sup>31</sup> Australian Institute of Health and Welfare. Dementia in Australia. 2012 [Internet]. Canberra (ACT): AIHW; 2012 [cited 2024 Jun 11]. Available from [www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422943](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422943)

<sup>32</sup> Alzheimer's Australia. Fight Alzheimer's Save Australia, Submission to the Productivity Commission: Reforms to Human Services (Stage 2) [Internet]. Barton (ACT): AA; 2017 July [cited 2024 Jun 11]. Available from [https://www.pc.gov.au/data/assets/pdf\\_file/0016/214054/sub431-human-services-reform.pdf](https://www.pc.gov.au/data/assets/pdf_file/0016/214054/sub431-human-services-reform.pdf)

<sup>33</sup> Durning SJ, Artino AR, Holmboe E, Beckman TJ, Van Der Vleuten C, Schuwirth L. Aging and cognitive performance: challenges and implications for physicians practicing in the 21st century. *J Contin Educ Health Prof* [Internet]. 2010 Jun [cited 2024 Jun 12]; 30(3):153-60. Available from: <https://pubmed.ncbi.nlm.nih.gov/20872769/>

<sup>34</sup> Adler RG, Constantinou C. Knowing—or not knowing—when to stop: cognitive decline in ageing doctors. *Med J Aust* [Internet]. 2008 Dec [cited 2024 Jun 12]; 189(11-12):622-4. Available from: <https://pubmed.ncbi.nlm.nih.gov/19061450/>

until approximately age 60 followed by a plateau until age 80, and there is steady decline in fluid abilities from age 20 to age 80.<sup>35</sup>

Because of decline in fluid intelligence, adults aged in their 70s typically take about twice as long to process the same tasks as adults in their 20s.<sup>23</sup>

Executive cognitive function - which involves decision making, problem solving, planning and sequencing of responses, and multitasking - declines with advancing age.<sup>36</sup> Executive cognitive function is particularly important for novel tasks for which a set of habitual responses is not necessarily the most appropriate response and depends critically on the prefrontal cortex. Performance on tests that are novel, complex or timed, steadily decline with advancing age, as does performance on tests that require inhibiting some responses but not others or involve distinguishing between relevant and irrelevant information. In addition, concept formation, abstraction, and mental flexibility decline with age, especially in subjects older than age 70.<sup>37</sup>

Adler and Constantinou suggest that brighter, better educated individuals may be at lower risk of age-related cognitive decline<sup>33</sup> and Peisah and Wilhelm suggest that higher education may be protective of cognitive decline<sup>38</sup>. However, the protective effects may be restricted to certain cognitive abilities, such as crystallised intelligence (i.e., accumulated knowledge) and memory, and even the best performers decline in one or more abilities late into old age.

Regarding cognitive functioning, Kataria and colleagues examined the performance assessments and cognitive function in 109 practitioners over the age of 45 years referred to the National Clinical Assessment Service (NCAS) between 1 September 2008 and 30 June 2012.<sup>39</sup> The majority of reasons for referral included 'clinical difficulties' and 'governance or safety issues'. Eighty-seven practitioners scored above 88 on ACE-R (a cognitive screening test).<sup>40</sup> Twenty-two were found to have an ACE-R score of <88, indicating a potential cognitive issue. On further assessment, 14 of these 22 practitioners (15%) were found to have cognitive impairment. The majority of all practitioners were found to be performing below the expected level of practice for someone at their grade and specialty and the youngest doctor with a cognitive deficit in this study was 46 years old. Many were working in isolation indicating a lack of professional/peer supports. They called for increased vigilance for cognitive impairment.

A small study in Ontario, Canada considered if physicians with identified competency concerns had neuropsychological impairments sufficient to explain their incompetence and their failure to improve after remedial continuing medical education. It demonstrated that more than a third of the 45 doctors had moderate to severe cognitive impairment.<sup>41</sup>

It is difficult to relate the precise degree of neurocognitive loss to doctors' competence because the actual levels of cognitive impairment that preclude safe practice have not been determined. There are no agreed guidelines to help medical boards decide what level of cognitive impairment in a doctor

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<sup>35</sup> Murman DL. The impact of age on cognition. *Semin Hear* [Internet]. 2015 Aug [cited 2024 Jun 12]; 36(3):111-21. Available from: <https://pubmed.ncbi.nlm.nih.gov/27516712/>

<sup>36</sup> Lezak MD, Howieson DB, Bigler ED, Tranel D. *Neuropsychological Assessment*. 5th ed. New York: Oxford University Press; 2012

<sup>37</sup> Salthouse T. Consequences of age-related cognitive declines. *Annu Rev Psychol* [Internet]. 2012 Jan 10 [cited 2024 Jun 12]; 63:201-26. Available from: <https://pubmed.ncbi.nlm.nih.gov/21740223/>

<sup>38</sup> Peisah C, Wilhelm K. The impaired ageing doctor. *Intern Med J* [Internet]. 2002 Sep 1 [cited 2024 Jun 12]; 32(9-10):457-9. Available from: <https://pubmed.ncbi.nlm.nih.gov/12380698/>

<sup>39</sup> Kataria N, Brown N, McAvoy P, Majeed A, Rhodes M. A retrospective study of cognitive function in doctors and dentists with suspected performance problems: an unsuspected but significant concern. *JRSM open* [Internet]. 2014 Apr 9 [cited 2024 Jun 12]; 5(5):2042533313517687. Available from: <https://pubmed.ncbi.nlm.nih.gov/25057390/>

<sup>40</sup> Mioshi E, Dawson K, Mitchell J, Arnold R, Hodges JR. The Addenbrooke's Cognitive Examination Revised (ACE-R): a brief cognitive test battery for dementia screening. *Int J Geriatr Psychiatry* [Internet]. 2006 Nov [cited 2024 Jun 12]; 21(11):1078-85. Available from: <https://pubmed.ncbi.nlm.nih.gov/16977673/>

<sup>41</sup> Turnbull J, Cunningham J, Unsal A, Norman G, Ferguson B. Competence and cognitive difficulty in physicians: a follow-up study. *Acad Med* [Internet]. 2006 Oct 1 [cited 2024 Jun 12]; 81(10):915-8. Available from: <https://pubmed.ncbi.nlm.nih.gov/16985357/>

may put the public at risk.<sup>33</sup> Screening tests may require further investigation when impairment is suspected. However, LoboPrabhu et al. raise the question of whether age should be considered as a risk factor that merits special screening for adequate cognitive functioning.<sup>42</sup>

Some doctors have difficulty recognising limitations of their standards of care, particularly as their sustained attention, reaction time, visual learning and memory decreases markedly after 75 years of age.<sup>43</sup> And while with age there is an accumulated wisdom and verbal knowledge, there is an overall decline in cognitive processing efficiency which may affect their ability to know when to change their scope of practice or stop practising.<sup>33</sup>

## Notifications

Unsafe medical care, where patients are harmed by the medical care designed to help them, can have wide-ranging consequences.<sup>44</sup> Thomas and Peterson have identified that adverse events, or injuries as a result of medical care, lead to direct harm and waste, and have spillover effects on patient confidence in the healthcare system<sup>45</sup> and Shojania et al. suggest 'that tens of thousands of citizens are injured, or die, due to medical errors'.<sup>46</sup>

Notifications from patients, other doctors or health professionals and members of the community are the primary way the Board deals with concerns about unsafe practices, unprofessional behaviours or the health of doctors.

Generally, older doctors are the subject of more notifications (complaints) compared with younger doctors. These include complaints about health and cognitive impairment which can impact on safe patient care, particularly when accompanied by a lack of insight.

## Notifications received 2015 to 2023

An analysis of notifications made to Ahpra in 2015, 2019 and 2023, highlights there are significantly more notifications made about older doctors, particularly about clinical care, communication, documenting records and reports and prescribing or supply of medicines.

The following graphs provide notifications data and show that higher rates of notifications about doctors aged 70 years and older have increased over the eight years from 2015.<sup>47</sup>

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<sup>42</sup> LoboPrabhu SM, Molinari VA, Hamilton JD, Lomax JW. The aging physician with cognitive impairment: approaches to oversight, prevention, and remediation. *Am J Geriatr Psychiatry* [Internet]. 2009 Jun 1;17(6):445-54. Available from: <https://pubmed.ncbi.nlm.nih.gov/19461256/>

<sup>43</sup> Bieliauskas LA, Langenecker S, Graver C, Lee HJ, O'Neill J, Greenfield LJ. Cognitive changes and retirement among senior surgeons (CCRASS): results from the CCRASS Study. *J Am Coll Surg* [Internet]. 2008 Jul 1 [cited 2024 Jun 12]; 207(1):69-78. Available from: <https://pubmed.ncbi.nlm.nih.gov/18589364/>

<sup>44</sup> Jha AK, Larizgoitia I, Audera-Lopez C, Prasopa-Plaizier N, Waters H, Bates DW. The global burden of unsafe medical care: analytic modelling of observational studies. *BMJ Qual Saf* [Internet]. 2013 Oct 1 [cited 2024 Jun 12]; 22(10):809-15. Available from <https://pubmed.ncbi.nlm.nih.gov/24048616/>

<sup>45</sup> Thomas EJ, Petersen LA. Measuring errors and adverse events in health care. *J Gen Intern Med* [Internet]. 2003 Jan [cited 2024 Jun 12]; 18:61-7. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494808/>

<sup>46</sup> Shojania KG, Duncan BW, McDonald KM, Wachter RM, Markowitz AJ. Making health care safer: a critical analysis of patient safety practices. *Evid Rep Technol Assess (Summ)* [Internet]. 2001 Jan 1 [cited 2024 Jun 12] (43):i-x. Available from: <https://pubmed.ncbi.nlm.nih.gov/11510252/>

<sup>47</sup> Australian Health Practitioner Regulation Agency. Ahpra notifications data 2015, 2019, 2023. Melbourne (AU). (Unpublished)

### Number of notifications received about late career doctors

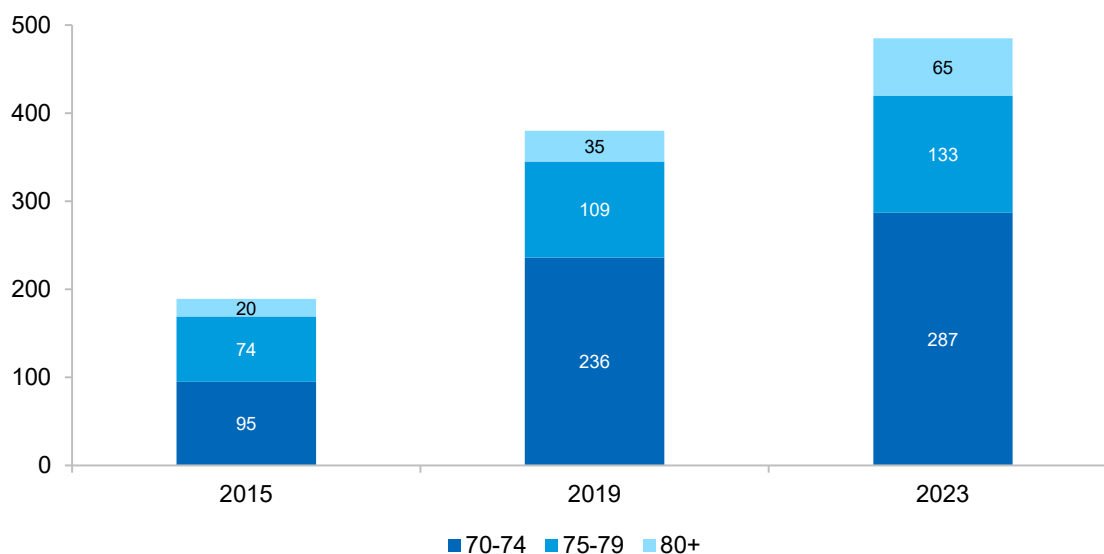


Figure 7: Number of notifications received about late career doctors (excluding doctors holding non-practising registration)

Figure 7 shows the increase in notifications received about late career doctors over the eight years from 2015, broken down by age groups 70-74 years, 75-79 years and 80 years and older.

Notifications have increased from 189 in 2015 to 485 in 2023.

### Notifications received per 1000 doctors

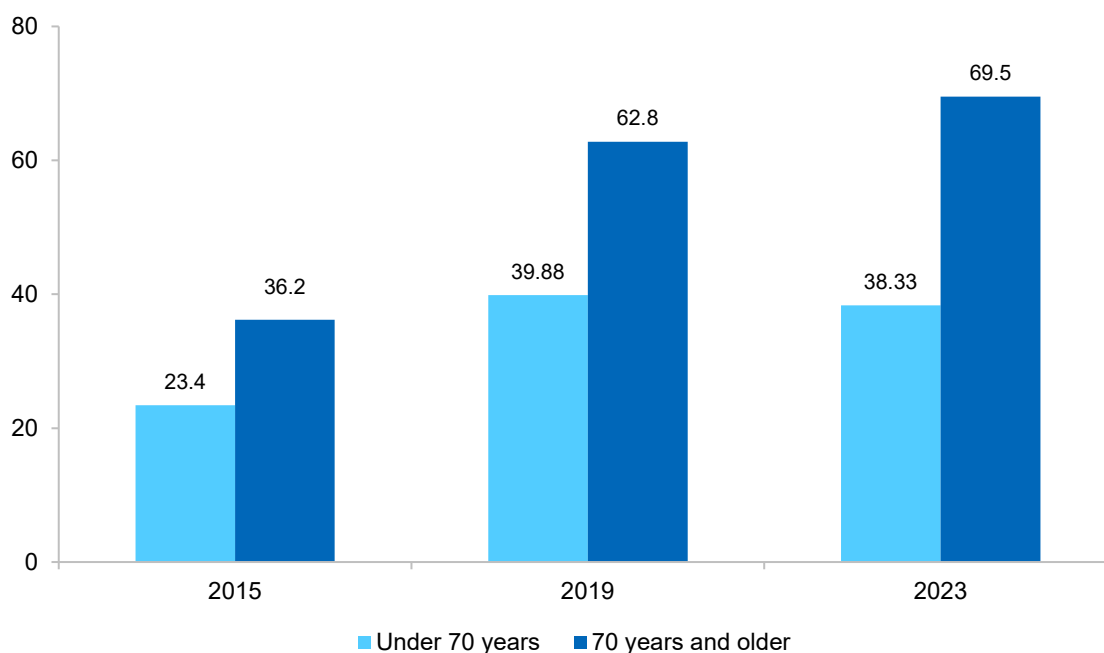


Figure 8: Notifications received per 1000 doctors (excluding doctors holding non-practising registration)

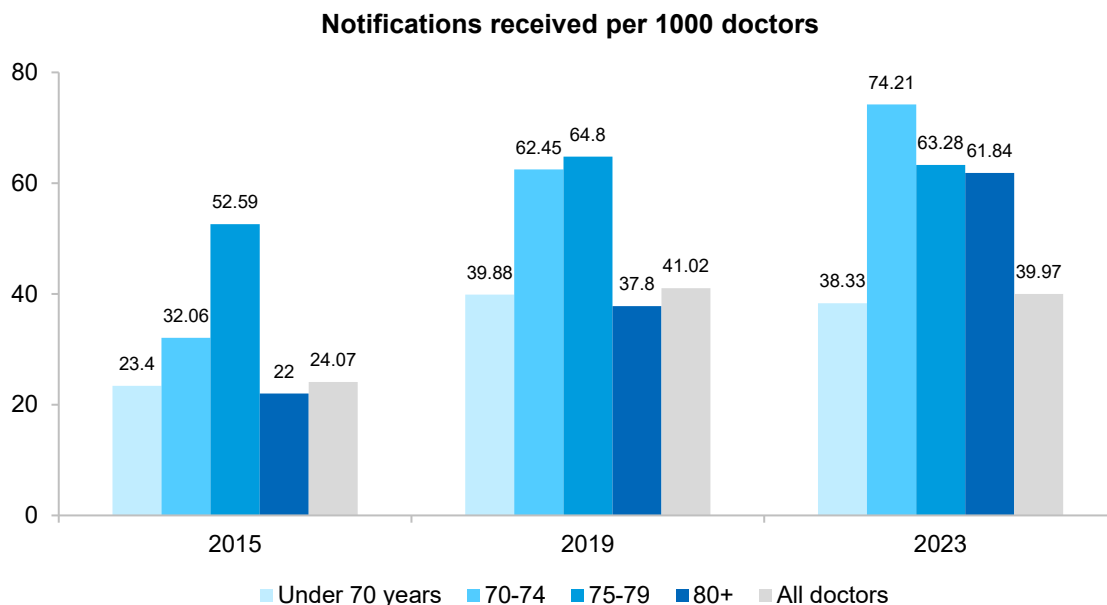


Figure 9: Notifications received per 1000 doctors (excluding doctors holding non-practising registration)

Figures 8 and 9 show the distribution of notifications per 1000 doctors in each age group. In 2023, notifications about late career doctors were 81% higher than for doctors under 70 years of age. Notifications about 70-74 year old doctors were 93% higher than for doctors under 70 years old (38.33 up to 74.21 per 1000).

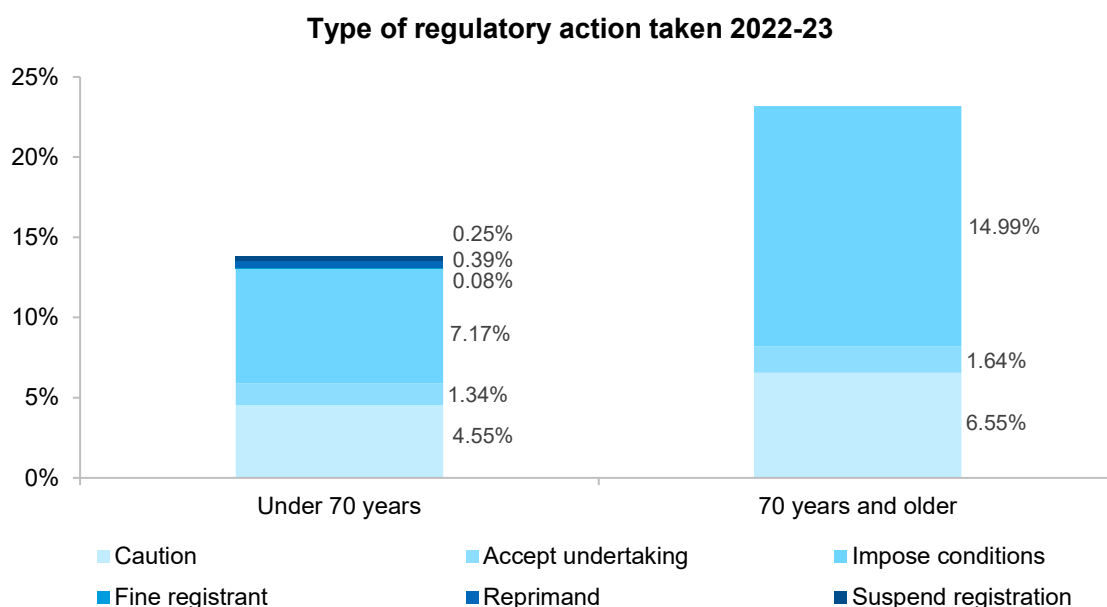


Figure 10: Type of regulatory action taken in 2022-23 (excluding doctors holding non-practising registration and matters referred to another body or retained by HCE)

Figure 10 shows the Board took regulatory action in 23.2% of notifications made about late career doctors, compared with 13.8% of notifications made about doctors younger than 70 years. This is 1.7 times more frequently for late career doctors.



## Types of notifications per 1000 doctors<sup>48</sup>

	2015		2019		2023	
	Under 70 years	70 years and older	Under 70 years	70 years and older	Under 70 years	70 years and older
Behaviour	0.2940	0.9576	1.8732	3.3811	1.2202	2.1505
Billing	0.1890	0.1915	0.5638	0.3220	0.8773	0.5734
Boundary violation	0.5249	1.3400	1.3276	2.5761	0.8693	1.2903
Breach of non-offence provision in the National Law	0.3150	0.5746	0.3819	0.3220	0.3030	0.5735
Clinical care	7.6011	9.7682	22.1151	31.3959	15.9182	24.2293
Communication	1.0394	1.1492	2.2278	5.3132	4.6973	11.3261
Confidentiality	0.4094	0.1915	0.6638	0.3220	0.6460	0.5735
Conflict of interest	0.0525		0.1091	0.1610	0.0718	
Discrimination	0.0420		0.1182		0.0798	0.2867
Documentation	0.6929	1.3407	1.7823	4.0251	1.9539	5.0179
Health impairment	1.0709	1.5322	1.1730	1.7710	0.6300	2.5806
Infection/hygiene	0.0315	0.3830	0.1364	0.4830	0.1595	0.5735
Informed consent	0.1784		0.6365	0.6440	0.6779	1.0035
Medico-legal conduct	0.0945	0.3830	0.0909	0.1610	0.0718	0.2867
Offence against other law			0.5365	0.4830	0.6539	0.5735
Other	0.2310	0.7661	0.2364	0.6440	0.9730	1.7204
Pharmacy/medication	1.0814	1.7238	4.0466	5.9571	4.6415	12.1864
Response to adverse event	0.0210		0.0818	0.1610	0.1515	0.1434
Statutory offence	0.2100		0.1000		0.0319	
Teamwork/supervision	0.0315	0.1915	0.1728		0.1037	0.2867

*Table 1: Types of notifications per 1000 doctors (excluding doctors holding non-practising registration)*

Table 1 shows the breakdown of the types of notifications received. It highlights the significantly higher rates of notifications for doctors aged 70 years and older, particularly about clinical care, communication, documenting records and reports and prescribing or supply of medicines.

<sup>48</sup> Doctors holding practising registration at 30 June 2023  
Where the reason for the notification is not recorded in the Ahpra classification data, these notifications have been removed from the table. The number of notifications removed are as follows:  
2015: Under 70 years = 9.28 (884 unadjusted) 70 years and older = 15.71 (82 unadjusted)  
2019: Under 70 years = 1.51 (166 unadjusted) 70 years and older = 3.06 (19 unadjusted)  
2023: Under 70 years = 3.60 (451 unadjusted) 70 years and older = 4.15 (29 unadjusted)

A comprehensive study conducted in 2018 by Thomas et al. is the most recent detailed, peer reviewed research into notifications (complaints) made to Ahpra about the health, performance and/or conduct of doctors in Australia.<sup>49</sup> This study is particularly relevant as it is based on data from the National Scheme.

The research confirms that doctors aged 65 years and older were at higher risk for notifications relating to physical or cognitive impairment, records and reports, prescribing or supply of medicines, disruptive behaviour and treatment and lower risk for notifications about mental illness or substance misuse than younger doctors.

The retrospective cohort study looked at a national dataset of 12,878 notifications lodged with Ahpra between 1 January 2011 and 31 December 2014. The notifications received about all registered doctors in Australia aged 36 to 60 (younger doctors) and 65 years or older (older doctors) during the study period were reviewed to determine the incidence rates of notifications and incidence rate ratios of notifications (older versus younger doctors).

The results confirmed older doctors had notification rates 1.4 times higher than for doctors aged 36 to 60 years (90.9 compared with 66.6 per 1000 practitioner years<sup>50</sup>). Notifications resulting in regulatory action such as a reprimand, fine or imposition of conditions was 1.5 times higher among doctors aged 65 years and older.

Importantly, the notification rates relating to physical illness or cognitive decline was 15.5 times higher for older doctors than for doctors aged 36 to 60 years (incidence rate ratio = 15.54).

Older doctors also had higher complaint rates for a number of other issues, although to a lesser degree than for physical illness or cognitive decline. Specifically:

- inadequate record keeping (incidence rate ratio = 1.98)
- unlawful use or supply of medications (incidence rate ratio = 2.26)
- substandard certificates/reports (incidence rate ratio = 2.02)
- inappropriate prescribing (incidence rate ratio = 1.99)
- disruptive behaviours (incidence rate ratio = 1.37)
- substandard treatment (incidence rate ratio = 1.24).

Older doctors had lower notification rates relating to mental illness and substance misuse (incidence rate ratio = 0.58) and for performance issues relating to problems with procedures (incidence rate ratio = 0.61).

This research confirms the Board's view that late career doctors experience physical illness and cognitive decline at a significantly higher rate than younger doctors and that health checks would assist in identifying these issues in older doctors, before potentially unsafe practice occurs, and notifications are made about the individual doctors.

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<sup>49</sup> Thomas LA, Milligan E, Tibble H, Too LS, Studdert DM, Spittal MJ, Bismark MM. Health, performance and conduct concerns among older doctors: a retrospective cohort study of notifications received by medical regulators in Australia. *Journal of Patient Safety and Risk Management* [Internet]. 2018 Apr [cited 2024 Jun 12]; 23(2):54-62. Available from: <https://journals.sagepub.com/doi/10.1177/2516043518763181> or [https://www.researchgate.net/profile/Laura-Thomas-29/publication/323939150\\_Health\\_performance\\_and\\_conduct\\_concerns\\_among\\_older\\_doctors\\_A\\_retrospective\\_cohort\\_study\\_of\\_notifications\\_received\\_by\\_medical\\_regulators\\_in\\_Australia/links/5e6996a0a6fdcc7595030d93/Health-performance-and-conduct-concerns-among-older-doctors-A-retrospective-cohort-study-of-notifications-received-by-medical-regulators-in-Australia.pdf](https://www.researchgate.net/profile/Laura-Thomas-29/publication/323939150_Health_performance_and_conduct_concerns_among_older_doctors_A_retrospective_cohort_study_of_notifications_received_by_medical_regulators_in_Australia/links/5e6996a0a6fdcc7595030d93/Health-performance-and-conduct-concerns-among-older-doctors-A-retrospective-cohort-study-of-notifications-received-by-medical-regulators-in-Australia.pdf)

<sup>50</sup> Practitioner years were calculated using two factors: Practitioner years were estimated at the doctor level, as a multiplicative function of two variables: (1) the amount of time in the study period each doctor was registered (denoted in fractions of years); and (2) the average number of clinical hours worked per week (denoted in fractions of 40 h, including values >1). The amount of time each doctor was registered was calculated directly from the AHPRA register data. The clinical hours per week was estimated from Health Workforce Australia's 2015 Health Workforce Survey, 19 using subgroup averages based on a matrix of values accounting for work hour differences by sex, specialty and age.

## Why is it a problem?

Many older doctors experience physical and cognitive decline, which may affect their ability to provide safe care. Applying current research findings, it is possible that a number of currently registered doctors aged 70 and older are at risk of poor performance caused by cognitive decline, while others are experiencing physical decline.

A doctor with a health condition may be impaired and have their judgement or performance affected. This can impact on their safe clinical management of patients.

The effect of age on any individual doctor's competence is highly variable and there are likely to be many reasons for this. Deterioration in health from any cause should be recognised so that the consequent issues can be managed proactively.

Given the unpredictable trajectory of physical and cognitive decline,<sup>51</sup> there is a need to ensure practitioners are aware of their current health so they can manage any potential impacts on their performance. Older practitioners may be able to modify their scope and style of practice and increase supports to mitigate physical and/or cognitive changes. The Board encourages this.

### Doctors are expected to maintain their health

Medicine can be both a satisfying and challenging profession. To provide good care to their patients, doctors need to take care of their own health and wellbeing. The Declaration of Geneva has been updated to include a commitment to this.<sup>52</sup>

The Board strongly encourages doctors to make a commitment to their own wellbeing and to assure their ability to provide safe care to their patients over the long term. This involves actively and regularly monitoring and managing their own health, including by identifying and addressing health concerns early, which avoids more serious impacts later.

The Board's Code of conduct makes explicit the standards of ethical and professional conduct expected of doctors:

*As a doctor, it is important for you to maintain your own health and wellbeing. This includes seeking an appropriate work-life balance.*

*Good medical practice involves:*

- *having a general practitioner*
- *seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment... and*
- *if you know or suspect that you have a health condition or impairment that could adversely affect your judgement, performance, or your patient's health, not relying on your own assessment of the risk you pose to patients...*

This has been the Board's expectation since the commencement of the National Scheme, in the first edition of *Good medical practice: a code of conduct for doctors in Australia* (2009)<sup>53</sup> as well as in guidelines developed by specialist medical colleges in Australia and New Zealand, the Australian Medical Association (AMA) *Code of Ethics*, and prior to 2010 by state and territory Medical Boards.

Similar expectations about standards of practice are provided by international medical regulators including the General Medical Council (GMC) of the United Kingdom, the Medical Council of New

<sup>51</sup> Blondell SJ, Hammersley-Mather R, Veerman JL. Does physical activity prevent cognitive decline and dementia?: A systematic review and meta-analysis of longitudinal studies. *BMC public health* [Internet]. 2014 May 27 [cited 2024 Jun 12]; 14:510. Available from: <https://pubmed.ncbi.nlm.nih.gov/24885250/>

<sup>52</sup> World Medical Association. Declaration of Geneva 2018 [Internet]. Ferney-Voltaire, France: WMA; 2014. [cited 2024 Jun 12]. Available from: <https://www.wma.net/policies-post/wma-declaration-of-geneva/>

<sup>53</sup> Australian Medical Council. *Good medical practice: a code of conduct for doctors in Australia* (2009) [Internet] Canberra (ACT). AMC. Available from: <https://www.amc.org.au/documentation-and-guides/the-development-of-good-medical-practice-a-code-of-conduct-for-doctors-in-australia-by-the-australian-medical-council/>

Zealand, the National Alliance for Physician Competence in the United States and the Royal College of Physicians and Surgeons in Canada. It is also consistent with the Declaration of Geneva and the *International Code of Medical Ethics*<sup>54</sup> issued by the World Medical Association.

Despite the Board's Code of conduct and advice from professional bodies, many doctors appear to not be effectively managing their own health. This does not appear to have changed since the commencement of the National Scheme in 2010.<sup>55</sup> The 2016 Royal Australasian College of Surgeons (RACS) *Workforce Census* indicates that approximately one third of respondents had not seen a general practitioner (GP) in the last two years, one third regularly see a GP and the remaining third as needed (for example, when they have a specific illness they judge to need medical attention).<sup>56</sup>

While supporting literature is somewhat limited, doctors have a reputation as reluctant patients, and the Board is concerned that doctors do not always seek the care they need. In a survey by Pullen et al. 26% of doctors reported feeling inhibited about consulting another doctor.<sup>57</sup>

Fox et al.<sup>58</sup> and Kay et al.<sup>59</sup> have identified reasons doctors do not acknowledge their illness or seek treatment. Reasons include embarrassment of exposing themselves to their peers, fears about confidentiality (or not wanting to share personal information with colleagues), pressure from other doctors and the community to be healthy, the personality of the doctor, fear of losing control, and the demands of working as a medical practitioner.

## Patients

Patients often develop a long-term relationship with their general practitioner and age along with them. Patients who are older in years are more likely to be loyal and more satisfied and trusting of their doctors and less likely to question their doctor's advice or treatment recommendations, particularly if there is a long-standing relationship.<sup>60</sup> They also report being less frequently involved in decisions about their health care and being overwhelmed by the complexity of information relating to their healthcare, leading to them to place more emphasis on the trust they place in their doctors<sup>61</sup> and have a preference to grant decisional authority to their doctor<sup>62</sup>. It is therefore vital their doctor has the physical and cognitive capacity to provide them with safe medical care.

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<sup>54</sup> World Medical Association. *International Code of Medical Ethics*. Ferney-Voltaire, France; WMA [Internet]; 2022 [cited 2024 Jun 12]. Available from: <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/>

<sup>55</sup> Thomas LA, Milligan E, Tibble H, Too LS, Studdert DM, Spittal MJ, Bismark MM. Health, performance and conduct concerns among older doctors: a retrospective cohort study of notifications received by medical regulators in Australia. *Journal of Patient Safety and Risk Management* [Internet]. 2018 Apr [cited 2024 Jun 12]; 23(2):54-62. Available from: <https://journals.sagepub.com/doi/10.1177/2516043518763181>

<sup>56</sup> Royal Australasian College of Surgeons. *Senior surgeons in active practice (2018)* [Internet] Melbourne (Vic): RACS; 2013 [cited 2023 Apr 16]. Available from: <https://www.surgeons.org/about-racs/position-papers/senior-surgeons-in-active-practice-2018>

<sup>57</sup> Pullen D, Lonie CE, Lyle DM, et al. Medical care of doctors. *Med J Aust* [Internet] 1995 May [cited 2024 Jun 12]; 162: 481, 484. Available from: <https://pubmed.ncbi.nlm.nih.gov/7746206/>

<sup>58</sup> Fox F, Harris M, Taylor G, Rodham K, Sutton J, Robinson B and Scott J. What happens when doctors are patients? Qualitative study of GPs. *Br J Gen Pract* [Internet]. 2009 Nov [cited 2024 Jan 17]; 59: 811-818. Available from: <https://bjgp.org/content/bjgp/59/568/811.full.pdf>

<sup>59</sup> Kay M, Mitchell G, Clavarino A and Doust J. Doctors as patients: a systematic review of doctors' health access and the barriers they experience. *Br J Gen Pract* [Internet]. 2008 Jul 1 [cited 2024 Jan 17]; 58: 501-508. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2441513/pdf/bjgp58-501.pdf>

<sup>60</sup> Platonova EA, Kennedy KN, Shewchuk RM. Understanding patient satisfaction, trust, and loyalty to primary care physicians. *Med Care Res Rev* [Internet]. 2008 Dec [cited 2024 Jun 12]; 65(6):696-712. Available from: <https://pubmed.ncbi.nlm.nih.gov/18723450/>

<sup>61</sup> Butterworth JE, Campbell JL. Older patients and their GPs: shared decision making in enhancing trust. *Br J Gen Pract* [Internet]. 2014 Nov 1 [cited 2024 Jun 12]; 64(628): e709-18. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4220232/>

<sup>62</sup> Trachtenberg F, Dugan E, Hall MA. How patients' trust relates to their involvement in medical care. *J Fam Pract* [Internet]. 2005 Apr 1 [cited 2024 Jun 12]; 54(4):344-54. Available from: <https://pubmed.ncbi.nlm.nih.gov/15833226/>

## Comparisons with other professions

In Australia, there is no mandatory retirement age for doctors, unlike judges or pilots. The total number of doctors over 65 years of age has increased by 80% since 2004,<sup>63, 64</sup> reflecting the baby boomer generation. Since Schofield and Beard reported on the effects of this generation in medical practitioners in 2005,<sup>65</sup> the medical workforce has continued to age, with 10.1% of all practising doctors in Australia aged 65 years and older in 2022.<sup>66</sup> The proportion of older doctors also differs within specialties. For example, the RACS reported in 2016 that 19% of its fellows were over the age of 65.<sup>67</sup>

Many doctors are reluctant to retire. Wijeratne and colleagues have reported a cross-sectional self-report survey of doctors aged 55 or older, using a commercial database rented from the Australasian Medical Publishing Company (AMPCo). In all, 62% of 1,048 respondents (17.5% response rate) intended to retire, 11.4% had no intention of retiring and 26.6% were unsure.<sup>68</sup>

Sherwood and Bismark have identified the key reasons surgeons put off retiring. These include 'personal fulfilment from work, lack of outside interests, financial pressures and poor retirement planning ... [and] the strong sense of identity that many surgeons find in their work'.<sup>69</sup>

In 2023, 8.4% of surgeons and 8.8% of general practitioners were aged 70 years or older.<sup>70</sup>

The Board believes that judges and pilots are two professions that require mental acumen similar to that required by doctors.

Judges and magistrates are required by law to retire between 65 and 72 years, depending on the state or territory. In most jurisdictions, judges who have reached retirement age can be reappointed as acting judges for a limited time on an ad hoc basis. In NSW, the age cut-off for acting judges is 77 years.<sup>71</sup> A 1977 constitutional referendum introduced judicial retirement ages, meaning judges of the High Court and Federal Court must retire at the age of 70 and cannot return as acting judges.<sup>72</sup>

It is recognised that because judicial decision making carries such important consequences it is necessary that judges be mentally competent and capable of performing those duties. Many consider that judges can often perform legal duties to a high standard beyond the age of 70 years, but there is

<sup>63</sup> Australian Institute of Health and Welfare. Medical practitioners workforce [dataset] 2020 [Internet]. Canberra (ACT): AIHW; 2020 Jul 23 [cited 2021 Apr 16]. Available from <https://www.aihw.gov.au/reports/australias-health/health-workforce>.

<sup>64</sup> Australian Institute of Health and Welfare. Medical labour force 2004. National Health Labour Force Series No.38. [Internet]. Canberra (ACT): AIHW; 2006 [cited 2021 Apr 16]. Available from <https://www.aihw.gov.au/reports/workforce/medical-labour-force-2004/data>

<sup>65</sup> Schofield DJ, Beard JR. Baby boomer doctors and nurses: demographic change and transitions to retirement. *Med J Aust* [Internet]. 2005 Jul [cited 2024 Jun 12]; 183(2): 80-3. Available from: <https://pubmed.ncbi.nlm.nih.gov/16022613/>

<sup>66</sup> Medical Board of Australia. Registration data June 2022 [Internet]. Melbourne (AU): Australian Health Practitioner Regulation Agency. 2022 Jul 28 [cited 2024 Jun 12]. Available from: <https://www.medicalboard.gov.au/News/Statistics.aspx>

<sup>67</sup> Sherwood R, Bismark M. The ageing surgeon: a qualitative study of expert opinions on assuring performance and supporting safe career transitions among older surgeons. *BMJ Qual Saf* [Internet]. 2020 Feb [cited 2024 Jun 12]; 29(2):113-121. Online supplementary appendix A. Available from: <https://qualitysafety.bmj.com/content/29/2/113.long>

<sup>68</sup> Wijeratne C, Earl JK, Peisah C, Luscombe GM, Tibbertsma J. Professional and psychosocial factors affecting the intention to retire of Australian medical practitioners. *Med J Aust* [Internet]. 2017 Mar [cited 2024 Jun 12]; 206(5):209-14. Available from: <https://pubmed.ncbi.nlm.nih.gov/28301791/>

<sup>69</sup> Sherwood R et al, Bismark M. The ageing surgeon: a qualitative study of expert opinions on assuring performance and supporting safe career transitions among older surgeons. *BMJ Qual Saf* [Internet]. 2020 Feb [cited 2024 Jun 12]; 29(2):113-121. Available from: <https://qualitysafety.bmj.com/content/29/2/113.long>

<sup>70</sup> Medical Board of Australia Registration data June 2023 In: Annual report 2022-2023 [Internet]. Melbourne (AU). Australian Health Practitioner Regulation Agency. 2023 November. [cited 2024 June 11] Available from: <https://www.medicalboard.gov.au/News/Annual-report.aspx>

<sup>71</sup> Whitbourn M. Push to raise judicial 'age of senility' from 72 to 75 [Internet]. Sydney (NSW); Sydney Morning Herald; [2017 August 26; cited 2021 April 16]. Available from: <http://www.smh.com.au/nsw/push-to-raise-judicial-age-of-senility-from-72-to-75-20170824-gy3fr.html>

<sup>72</sup> Blackham A. Judges and retirement ages. *Melbourne University Law Review* [Internet]. 2016 January [cited 2024 Jun 12]; 39(3):738-92. Available from: [https://law.unimelb.edu.au/\\_data/assets/pdf\\_file/0019/2061019/02-Blackham.pdf](https://law.unimelb.edu.au/_data/assets/pdf_file/0019/2061019/02-Blackham.pdf)

discussion within legal circles that as the demographic makeup of the Australian workforce changes, the mandatory age for judicial retirement should change with it.<sup>73</sup>

Upon retiring, Justice Graham Bell of the Family Court of Australia, the last judge appointed before the 1977 referendum, at the age of 78 was quoted as saying:

*Judges should be able to go on till 80 provided they pass a medical inspection ... They are sent out to pasture too early.*<sup>74</sup>

The Australian Law Reform Commission supports individual capacity-based assessment of judges, rather than compulsory retirement.<sup>75</sup>

The Australian Civil Aviation Safety Authority (CASA) requires all pilots to undergo periodic medical examinations throughout their career. After the age of 60, pilots must undergo six-monthly medical examinations, including a major examination every 12 months.<sup>76</sup>

Many airlines also require pilots to undergo mental health checkups. CASA requires licensed pilots to report depressive symptoms and relapses which may lead to short term grounding and mental health certification of pilots. Mental health checks of pilots are also required in Europe.<sup>77</sup>

In the UK, all pilots are required to have a medical assessment on an annual basis until the age of 60, after which the health check is required every six months<sup>78</sup> and in the United States of America pilots have a medical assessment on an annual basis until the age of 40, then every six months after that<sup>79</sup>.

## International examples

International regulatory practice designed specifically to address the risks to patient safety from poor performance and/or undetected physical or cognitive decline in doctors aged 70 and older include routine mandatory screening of the performance of practitioners over a certain age or length of clinical career, most commonly initially through multi-source feedback and/or a peer review process.

These approaches, whether focused on known risks due to age or applied to all registered practitioners, aim to proactively identify practitioners at risk of poor performance. If initial screening identifies performance concerns, practitioners are assessed more closely to identify the nature and extent of performance concerns. Tailored interventions and follow-up are applied to support and support return to safe practice if possible.

A systematic review by Bhat et al. identified 21 programs that assess ageing doctors' performance, 19 of which were in the United States.<sup>80</sup> They found the median age at which these programs were introduced was 70 (range 65–72) years and the frequency of reassessment varied between one and

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<sup>73</sup> Bradbury S. Constitutional Reform Unit Blog [Internet]. Constitutional critique: An ageing amendment – Section 72 and the mandatory retirement age of judges. University of Sydney; [published 2015 May 28; cited 2024 Jun 12]. Available from: <https://conreform.sydney.edu.au/2015/05/an-ageing-amendment-section-72-and-the-mandatory-retirement-age-of-judges/>

<sup>74</sup> Pelly M. Judges Put to Pasture Too Early, Says Bell. [Internet]. Sydney (NSW); The Australian; 2015 Feb 20 [cited 2024 Jun 12]

<sup>75</sup> Australian Law Reform Commission. Compulsory retirement [Internet]. Canberra (AU) Commonwealth of Australia. 2012 Sep 28 [cited 2024 Jun 12]. Available from: <https://www.alrc.gov.au/publication/grey-areas-age-barriers-to-work-in-commonwealth-laws-dp-78/2-recruitment-and-employment-law/compulsory-retirement/>

<sup>76</sup> Civil Aviation Safety Authority [Internet]. Phillip (ACT). Medical certification for ATPL holders over age 60; [updated 2021 Dec 7; cited 2023 June 29]. Available from: <https://www.casa.gov.au/licences-and-certificates/aviation-medicals-and-certificates/medical-certification-atpl-holders-over-age-60>

<sup>77</sup> EU to tighten checks of mental health of pilots [Internet]. Medical Express. [2018 Jul 25; cited 2023 Jun 29]. Available from: <https://medicalxpress.com/news/2018-07-eu-tighten-mental-health.html>

<sup>78</sup> Civil Aviation Authority [Internet]. London: UK. Medical requirements for professional pilots. [cited 2024 Jun 12]. Available from: <https://www.caa.co.uk/commercial-industry/pilot-licences/medical/uk-part-med-requirements/>

<sup>79</sup> Herstam J. Pilot medical certificates: Everything you need to know. [Internet] Quebec. Simple Flying [22 Mar 2023; accessed 9 Aug 2023]. Available from: <https://simpleflying.com/pilot-medical-certificates-complete-guide/>

<sup>80</sup> Bhat S, Chia B, Babidge W, Maddern GJ. Assessing performance in ageing surgeons: systematic review. Br J Surg [Internet]. 2023 Nov [cited 2024 June 12]; 110(11):1425-7. Available from: <https://pubmed.ncbi.nlm.nih.gov/37260108/>

five years, the most common being two-yearly. Four programs specifically targeted surgeons, the rest were aimed at the general doctor population, which included surgeons.

In these programs, physical and cognitive/neuropsychological assessment were much more prevalent, being an integral part of 18 and 17 of 21 programs respectively. Components of the physical examination varied, and included combinations of vision and hearing testing, and neurological and fine motor testing. Likewise, a variety of cognitive and neuropsychological testing tools were used across different programs. Six of 21 programs assessed the clinical performance of ageing physicians, often by analysing the medical records of their patients, and morbidity and mortality data.

In addition to the national dataset study by Thomas et al. that compared notifications lodged about registered doctors in Australia aged 36 to 60 and >65 years there are a number of international studies that have similar findings.<sup>29</sup>

Khalik and colleagues studied disciplinary regulatory action involving Oklahoma doctors. Among 14,314 currently or previously licensed medical practitioners, 396 (2.8%) had been disciplined. Using univariate proportional hazards analysis, men were found to be at greater risk of being disciplined than women.<sup>81</sup> Kaplan-Meier analysis revealed an age effect in that the proportion of medical practitioners disciplined increased with each successive 10-year interval since first licensure. Complaints against doctors most frequently involved issues related to quality of care (25%), medication/prescription violations (19%), incompetence (18%) and negligence (17%).

In 2014, the GMC reported that the relative proportions of doctors at higher risk of being complained about, being investigated or receiving a sanction or a warning showed that the highest risks arose for:<sup>82</sup>

- male doctors overall
- male doctors over 50 years old who are non-UK graduates, and
- male GPs aged 30–50 years who are non-UK graduates.

Donaldson et al.<sup>83</sup> conducted a large observational study using data collected by the independent National Clinical Assessment Service (NCAS)<sup>84</sup> in the UK for each referral for performance concerns (n=6179 doctors) over an 11-year period (2001–2012). The annual referral rate was five per 1,000 doctors. Referrals usually came from National Health Service (NHS) managers. Key findings included that doctors in the later stages of their career were nearly six times as likely to be referred as early-career doctors.

In Denmark, a study of complaints about GPs to the Danish Patient Complaints Board identified that, for complaints about daytime services, the professional seniority of the general practitioner was also positively associated with the odds of receiving a complaint decision (OR = 1.44 per 20 years of seniority; CI 95%, 1.04–1.98). Likewise, having more consultations per day was associated with increased odds (OR = 1.29 per 10 extra consultations per day; CI 95%, 1.07–1.54).<sup>85</sup>

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<sup>81</sup> Khaliq AA, Dimassi H, Huang CY, Narine L, Smego Jr RA. Disciplinary action against physicians: who is likely to get disciplined?. *Am J Med* [Internet]. 2005 Jul 1 [cited 2024 Jun 12]; 118(7):773-7. Available from: <https://pubmed.ncbi.nlm.nih.gov/15989912/>

<sup>82</sup> General Medical Council. Developing our understanding of risk: The state of medical education and practice in the UK report [Internet]. London: GMC; 2014 [cited 2021 Apr 16]. Available from [https://www.gmc-uk.org/-/media/documents/somep-2014-final\\_pdf-58751753.pdf](https://www.gmc-uk.org/-/media/documents/somep-2014-final_pdf-58751753.pdf)

<sup>83</sup> Donaldson LJ, Panesar SS, McAvoy PA, Scarrott DM. Identification of poor performance in a national medical workforce over 11 years: an observational study. *BMJ Qual Saf* [Internet]. 2014 Feb 1 [cited 2024 Jun 12]; 23(2):147-52. Available from: <https://qualitysafety.bmj.com/content/23/2/147.long>

<sup>84</sup> Note: The UK's [Practitioner Performance Advice](#) service was established in 2001 as the National Clinical Assessment Service (NCAS) to resolve concerns about the professional practice of doctors, dentists and pharmacists. PPA/NCAS provide a range of core services to NHS organisations and other bodies in England, Wales and Northern Ireland such as advice, assessment and intervention, training courses and other expert services.

<sup>85</sup> Birkeland S, Christensen RD, Damsbo N, Kragstrup J. Patient complaint cases in primary health care: what are the characteristics of general practitioners involved?. *Biomed Res Int* [Internet]. 2013 Jan 1 [cited 2024 Jun 12]; 2013:807204. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3763590/>

## 2. Why is government action needed?

A doctor who has a health condition may be a risk to their patients. Introducing preventative health checks to doctors over 70 years aims to build a culture that prioritises doctors' health and reduces the related risk to patients.

### Objectives of the proposed intervention

Healthy doctors are more likely to provide safer patient care.

The Board is exploring ways to enable doctors to better manage their own health, including facilitating access to treatment when it's needed, normalising conversations about doctors' health and supporting doctors' wellbeing. All are aimed at preventing avoidable risks to patients that can arise from unidentified or unaddressed health issues.

As identified in the previous section, there is strong evidence that there is a decline in performance and patient outcomes with increasing practitioner age, even when the practitioner is highly experienced.

Compared with younger doctors, this results in higher rates of complaints about health and cognitive impairment, record keeping and report writing, prescribing or supply of medicines, disruptive behaviour and treatment, all of which can impact on safe patient care, particularly when accompanied by a lack of insight. This has led to many examples of doctors with previously unblemished careers having been involved in regulatory action caused by their declining health as they age.

Published research referenced in this document confirms the Board's view that deterioration in health from any cause should be recognised so that the consequent issues can be managed proactively by late career doctors and their treating doctors.

Research and other policy levers (such as tests for older drivers, comprehensive health checks for older Australians, mandatory retirement ages or health checks for some professions) all vary as to the age at which health deteriorates and adverse impacts commence. In some research 65 years is cited, the aged pension is available from 67 years, judges must retire between 65 and 72 years and comprehensive health checks for the general population are Medicare funded from 75 years. The Board has considered this broad range of ages and is proposing *late career doctors* be defined as those aged 70 years and older. The Board is seeking feedback on this definition.

The Board is considering whether a general health check or fitness to practise assessment for late career doctors would enable doctors to make informed decisions about their health and practice and to address health related problems early to avoid more serious impacts to themselves and their patients later.

### The capacity to intervene

Governments have an interest in ensuring that regulatory frameworks achieve their stated objectives, including through the National Scheme for the regulation of health practitioners and registration of students. The National Scheme is founded on the National Law that is applied in each state and territory.

Health Ministers have governing responsibilities under the National Law. Ministers have directed that the National Law's paramount principle in administering the law are public protection and public confidence in the safety of health services. This direction has been confirmed in legislative changes that started on 21 October 2022. State and territory health ministers expect the Board to ensure public safety is not compromised by the health of doctors as they age.

Given the evidence described in the previous section, the health of late career doctors has the potential to compromise public confidence in the safety of the services they provide to their patients.



This, and the reluctance of many late career doctors to manage their own health, warrants action to protect the public.

The Board derives its powers from the National Law. It registers individual practitioners, manages notifications (complaints) about medical practitioners and sets standards. Medical practitioners are expected to comply with the National Law, registration standards approved by Australia's Health Ministers and Board approved codes and guidelines.

The Board must prioritise its responsibilities to protect the public while facilitating access to services in the public interest. The Board recognises there may be a small number of doctors who may not continue to practise if their health conditions are of a serious nature and that this may impact on some patients' access to health care. However, the Board must act within the scope of its powers under the National Law, particularly that the paramount considerations for administering the law are public protection and public confidence in the safety of these health services.

Under section 38 of the National Law, the Board can develop registration standards, for example, about 'the physical and mental health of registered health practitioners'. The Board is required to put forward advice and recommendations to Health Ministers.

Further wide-ranging public consultation on the options identified in this CRIS will provide the opportunity to test the strengths and weaknesses of these options and any additional options that have not been considered in this paper.

## Constraints and barriers

### Doctors are reluctant patients

The main constraint for the health checks or fitness to practice assessments is that there are some late career doctors who are reluctant patients.

The Board encourages all doctors to have their own independent general practitioner (GP) to manage their health and support their wellbeing. The Commonwealth Government provides specific funding through Medicare for health checks of 75+ year olds. However, doctors have a reputation as reluctant patients and many don't appear to be having routine health checks or seeking the health care they need, including by not acknowledging their illness or medical condition, or seeking treatment.

Twenty-six per cent of doctors have reported feeling inhibited about consulting another doctor<sup>86</sup> and cite reasons including embarrassment of exposing themselves to their peers, fears about confidentiality, pressure from other doctors and the community to be healthy, the personality of the doctor, fear of losing control, and the demands of working as a medical practitioner.<sup>87, 88</sup>

The Board has previously used 'behavioural insights' approaches to attempt to 'nudge' doctors to maintain their own health by publishing information for late career doctors about the value of maintaining good health. The information has been included in editions of the Board's monthly email newsletter which is the main way the Board communicates with doctors. This approach does not appear to have made significant differences to the notifications the Board receives and intervention from Government is therefore required to ensure doctors do not have health issues that may affect their ability to provide safe care.

While a reluctance to look after their health and particularly the fear of finding something adverse is understandable, the Board is concerned that late career doctors are not regularly seeking necessary medical care, given that health challenges escalate with age.

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<sup>86</sup> Pullen D, Lonie CE, Lyle DM, et al. Medical care of doctors. *Med J Aust* [Internet] 1995 [cited 2024 Jun 12]; 162: 481, 484. Available from: <https://pubmed.ncbi.nlm.nih.gov/7746206/>

<sup>87</sup> Fox F, Harris M, Taylor G, Rodham K, Sutton J, Robinson B and Scott J. What happens when doctors are patients? Qualitative study of GPs. *Br J Gen Pract* [Internet]. 2009 Nov [cited 2024 Jan 17]; 59: 811–818. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765832/pdf/bjgp59-811.pdf>

<sup>88</sup> Kay M, Mitchell G, Clavarino A and Doust J. Doctors as patients: a systematic review of doctors' health access and the barriers they experience. *Br J Gen Pract* [Internet]. 2008 [cited 2024 Jan 17]; 58: 501–508. Available from: <https://bjgp.org/content/bjgp/58/552/501.full.pdf>

Given this reluctance to see a GP regularly, the Board is looking at an alternative approach to provide reassurance to the Board and the community that older doctors' health issues are being managed.

An approved registration standard that requires late career doctors to have regular health checks would be the tool used to achieve these objectives, with the results of these health checks remaining confidential between the late career doctor and their treating doctor.

The Board recognises that some late career doctors may feel offended if either option two or three are implemented. They may feel their professionalism is undermined if they are required to undergo regular health checks. If the Board decides to introduce mandatory health checks or fitness to practise assessments (subject to consultation feedback), the Board would continue to provide information to late career doctors and work with stakeholders such as specialist medical colleges to encourage compliance with the registration standard.

Further details about the implementation timeframes are included in Part B, question 6: *What is the best option from those considered and how will it be implemented?*

### 3. What policy options are to be considered?

The Board is considering three options to ensure the health of doctors aged 70 years and older. The three options are:

1. rely on existing guidance (Status quo)
2. require a detailed health assessment of the 'fitness to practise' of doctors aged 70 years and older
3. require a general health check for late career doctors.

#### What options are available to the Board?

The Board derives its powers and responsibilities from the National Law. The Board must prioritise its responsibilities to protect the public while also facilitating access to services in accordance with the public interest. The Board can only act within the scope of its powers under the National Law.

Under section 38 of the National Law, the Board can develop registration standards, for example, about the physical and mental health of applicants for registration in the profession, registered health practitioners and students. Registration standards must be approved by Ministerial Council for the National Scheme (the Health Ministers of the Commonwealth, state and territory governments) and set out requirements that *must* be met to obtain and retain registration in that profession. The consequences of failing to comply with a registration standard are set out in the National Law, and include:

- the Board can impose a condition or conditions on a doctor's registration or can refuse their application for registration or renewal of registration, if they don't meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)
- a failure to meet the requirements of an approved standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the Board (section 128 of the National Law), and
- registration standards, codes or guidelines may be used in disciplinary proceedings against a doctor as evidence of what constitutes appropriate practice or conduct for health professionals (section 41 of the National Law).

Under section 39 of the National Law, the Board may also develop and approve codes and guidelines to provide guidance to the health practitioners it registers. Registration standards, codes or guidelines apply to all medical practitioners in all states and territories.

While both registration standards and codes and guidelines can be used in disciplinary proceedings as evidence of what constitutes appropriate professional conduct or practice for the health profession, under the National Law, registration standards hold greater statutory force and enforceability.

The OIA requires that all *feasible* options are considered. The Board has considered a range of options relevant to the health of late career doctors and the views of stakeholders are being sought on three feasible options.

The Board has identified the following three options as feasible options in relation to the health of late career doctors.

## Option 1: Rely on existing guidance (Status quo)

Under Option 1, the Board would rely on late career doctors to manage their physical and cognitive health by following the existing guidance in the Code of conduct. The Code 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. The Code is also used by the Board when they consider notifications (complaints) about a doctor's professional conduct.

The Code states that good medical practice includes doctors having their own GP and seeking independent, objective advice when they need medical care, and being aware of the risks of self-diagnosis and self-treatment.

Most Australians consult their assessing/treating doctor more frequently as they get older because the health issues they face increase. The Australian government has recognised the importance of health checks in older Australians by providing Medicare items for health assessments of older persons aged 75 years and over.<sup>89</sup> These assessments are available for late career doctors; however, doctors have a reputation as reluctant patients with a propensity for corridor consultations which do not always have the benefit of a formalised and well documented consultation with an independent practitioner. This means the majority of doctors do not seek treatment for a health issue or declare they have an impairment because they are often unaware they have one.

In addition to the Code of conduct, the Board has previously used 'behavioural insights' approaches to attempt to 'nudge' doctors to maintain their own health by publishing information for late career doctors about the value of maintaining their own good health. As well as frequent newsletter articles, the Board also funds free independent doctors' health services that are able to support ageing doctors. 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.

Given that the Board receives a disproportionate number of notifications about older practitioners, particularly around physical and cognitive impairment, the existing guidance in the Code of conduct and 'behavioural insights' have not had the desired effect.

### *How this option will meet the policy objectives*

The Board believes relying on the status quo would not enable individual doctors to make informed decisions about their health and practice and help them to address health related problems early to avoid more serious impacts to themselves and their patients later. Therefore, the Board does not believe this option best meets the policy objectives of the proposal or of the National Law and the National Scheme – which is to protect the public and ensure public confidence in the safety of services provided by registered health practitioners.

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<sup>89</sup> Department of Health and Aged Care. Health assessment for people aged 75 years and older [Internet]. Canberra (AU). Commonwealth of Australia [updated 2014 Apr 10; cited 2024 Jun 12] Available from: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare\\_mbsitem\\_75andolder](https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_75andolder)

## **Option 2: Require a detailed health assessment of the ‘fitness to practise’ of doctors aged 70 years and older**

Option 2 would see the Board requiring a detailed health assessment of all practising 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 that would specifically assess each doctor’s fitness to practise.

### **Details of option 2: fitness to practice assessment for late career doctors**

#### *Who would have the fitness to practice assessment?*

This option involves the Board requiring all registered doctors over the age of 70 years, except those with non-practising registration, to have a fitness to practice assessment. Practitioners with non-practising registration are not allowed to practise or provide health services (such as providing repeat prescriptions or a referral to a specialist, including to family and friends) and therefore they do not pose a risk to the public.

Doctors who do not directly provide clinical care, such as those practising in medical administration or medico-legal practice who require a practising form of registration and whose work impacts on patients, consumers or the community would be required to have the assessment.

#### *Who would do the fitness to practice assessments*

Fitness to practise assessments are usually undertaken by a specialist occupational and environmental medicine physician or other suitably qualified and trained doctor. The assessment includes an independent clinical assessment of the current and future capacity of the doctor to practise medicine.

#### *Components of the fitness to practice assessments*

Each assessment is specific to the individual doctor and would vary depending on the scope of practice or specialty of the doctor and their work environment. The assessment identifies any health issues, injuries or illnesses which may affect the doctor’s ability to provide safe care and includes recommendations for the best way to manage the situation to maintain the health and safety of the individual doctor.

For example, a surgeon’s dexterity, ability to stand, capacity to hear and see, and give instructions would be assessed.

The fitness to practice assessments would also include the elements of the general health check outlined in option three. These are:

- personal details
- social and family history
- current professional practice
- plans for the future
- health support
- past history
- medications
- allergies and vaccinations
- lifestyle
- current health issues
- recent investigations
- alcohol and substance review
- sleep
- cognitive function
- cardiovascular
- diabetes
- respiratory
- gastro-intestinal
- genito-urinary
- mental health
- neurological
- musculo-skeletal
- manual dexterity
- skin/haematological
- hearing
- sight
- endocrine.

This option would also require the Board to develop a range of clinical assessment resources relevant to each medical specialty and scope of practice to ensure fairness and consistency in the assessments. If this option is supported by stakeholders, significant investment and further consultation on these resources would be required prior to finalising the content. The Board has not developed resources at this time.

### *When the fitness to practice assessment would start and how frequently they would occur*

The fitness to practice assessments of option two includes that they are mandatory at three-yearly intervals from the age of 70 years and yearly over the age of 80 years. This is based on clinical advice that yearly health checks are not warranted for all doctors until the age of 80, but that a three-year interval for doctors between 70 and 80 years would allow for early intervention in identifying emerging health issues that can be effectively managed.

### *Screening of cognitive function*

A cognitive function assessment may also be required to determine capacity for complex problem analysis and decision-making. However, there is significant debate about the approach to cognitive assessment, given the limited sensitivity of screening tests in detecting mild cognitive impairment in highly functioning professionals, including doctors.

There are several tools identified in *Screening cognitive function in late career doctors* ([Part D: C-3](#)) that can be used as a starting point for screening cognitive function. These tools would need to be modified to reflect the individual nature of a fitness to practice assessment and may require the input of a specialist psychiatrist.

### *Role of the Board in relation to fitness to practice assessments*

An approved registration standard that requires late career doctors to have regular health checks would be the tool used to achieve the objectives of this option.

The fitness to practice assessment would be confidential between the late career doctor and their assessing/treating doctor. When issues are identified, action to address the health issues and/or to assist the return of the late career doctor to safe practice, would ideally be conducted at arms-length from the Board.

There would be no requirement to report the outcome of the assessment to the Board or Ahpra, unless the doctor has been found to pose a substantial risk to the public that is not being managed. [Mandatory reporting](#) is only likely to be necessary where unmanaged substantial risk is identified. When unaddressed health issues lead to substantial risk to patients, the Board may require a Board arranged [health assessment](#) with an independent assessor, in addition to the fitness to practice assessment, and may take regulatory action.

The late career doctor would be asked to declare in their annual registration renewal that they have completed the appropriate fitness to practice assessment. As they do now, they would also need to declare whether they have an impairment that detrimentally affects, or is likely to detrimentally affect, their capacity to practise medicine.

### *How this option will meet the policy objectives*

While a fitness to practise assessment for late career doctors would enable individual doctors to make informed decisions about their health and practice and address health related problems early to avoid more serious impacts to themselves and their patients later, the Board considers this is a high-impact option. The assessments would be lengthy and high cost, requiring highly specialised testing that in turn would require training and credentialing of assessing doctors, payment for the assessments and payment for using some cognitive testing resources.

### Option 3: Require general health checks for late career doctors

Option 3 is to require doctors aged 70 years and older to undergo general health checks every three years, and yearly from 80 years of age. The Australian Government has recognised the importance of health checks in older Australians by providing Medicare items for health assessments of older persons aged 75 years and over.<sup>90</sup> The general health check is similar to these assessments. It is NOT a detailed 'fitness to practise' health assessment (Option 2).

A general health check for late career doctors would provide information about the doctor's health that can lead to a discussion with the assessing doctor about the impact of the health concerns on their practice. It would also provide the opportunity for early intervention in managing health issues before they escalate and provide the opportunity for the late career practitioner to make informed decisions about the impact on their practice and give them the opportunity to manage the related risk to patients. It would also promote conversations about doctors' health within the medical community and facilitate access to treatment when it's needed as well as to support doctors' wellbeing. The results of the health check would NOT be shared with the Board.

A doctor who has previously had a health assessment as part of their general health care would not need to undertake a further general health check purely to meet this requirement.

#### Details of option 3: general health check for late career doctors

##### *Who would have the general health check?*

The Board is proposing that all registered doctors over the age of 70 years be required to have a general health check, except those with non-practising registration. Practitioners with non-practising registration are not allowed to practise or provide health services (such as providing repeat prescriptions or a referral to a specialist, including to family and friends) and therefore they do not pose a risk to the public.

Doctors who do not directly provide clinical care, such as those practising in medical administration or medico-legal practice who require a practising form of registration and whose work impacts on patients, consumers or the community would be required to have health checks.

##### *Who would do the general health check?*

The Code of conduct identifies the importance of doctors maintaining their own health and wellbeing, including having a regular GP for their ongoing medical care.<sup>91</sup>

The Board is proposing a very flexible approach to the general health check. In most instances, the checks would be conducted by the late career doctor's regular GP, with some components of the health check able to be performed by other health practitioners with relevant expertise, such as audiologists, optometrists, or nursing staff in the general practice.

In this paper, we use the term 'assessing/treating doctor' to describe the doctors who undertake the health checks of late career doctors.

The Board recognises that there may be some GPs who do not feel comfortable performing health checks on their late career colleagues. Also, the late career doctor's regular GP may not feel that they can perform the health check in the objective manner which is required. Equally, some late career doctors may already have conditions being actively treated and monitored by other specialists or health professionals.

The Board is very flexible about who will perform the health check. It could be a late career doctor's regular GP, another GP or another specialist. It is also flexible about the approach so that some parts

<sup>90</sup> Department of Health and Aged Care. Health assessment for people aged 75 years and older [Internet]. Canberra (AU). Commonwealth of Australia [updated 2014 Apr 10; cited 2024 Jun 12] Available from: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare\\_mbsitem\\_75andolder](https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_75andolder)

<sup>91</sup> Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia [Internet]. Melbourne (AU). MBA; 2020 Oct [cited 2024 Jun 11]. Available from: <http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>

of the health check may be conducted using telehealth, particularly for late career doctors working and living in rural and remote areas.

Doctors may already have had health checks for a variety of reasons. Information obtained during a health check for other reasons could be used for the Board mandated health check, avoiding an unnecessary duplication of services or a separate process.

The Board recognises that resources and educational packages would need to be provided to support GPs as the health check is implemented. However, these resources would not be viewed as mandatory or be a barrier to involvement. The Board is not proposing mandated additional certification or training for those conducting health checks.

The Board is not proposing to develop an 'appeals process' as the health checks are general, not assessing 'fitness to practise' and results would remain confidential between the late career doctor and their assessing/treating doctor. As with any health condition that requires more specialised advice, the late career doctor could be referred to a relevant specialist for further advice and management.

### *Components of the general health check*

The Board is not prescribing how the general health check should be undertaken.

The general health check is broad and includes the following domains. Details are provided in the draft questionnaire and examination sheet (Part D: [C-1](#) and [C-2](#)):

- personal details
- social and family history
- current professional practice
- plans for the future
- health support
- past history
- medications
- allergies and vaccinations
- lifestyle
- current health issues
- recent investigations
- alcohol and substance review
- sleep
- cognitive function
- cardiovascular
- diabetes
- respiratory
- gastro-intestinal
- genito-urinary
- mental health
- neurological
- musculo-skeletal
- manual dexterity
- skin/haematological
- hearing
- sight
- endocrine.

### *When the general health check would start and how frequently they would occur*

The Board's *Code of conduct* and the Royal Australian College of General Practitioners (RACGP) *Guidelines for preventive activities in general practice*<sup>92</sup> outline the validity of health checks throughout life. Regular health checks are not only 'good practice', but they also establish a baseline for ongoing review.

The Board's proposal for general health checks includes that they are mandatory at three-yearly intervals from the age of 70 years and yearly over the age of 80 years. This is based on clinical advice that yearly health checks are not warranted for all doctors until the age of 80, but that a three-year interval for doctors between 70 and 80 years will allow for early intervention by identifying emerging health issues that can be effectively managed.

### *Screening of cognitive function*

There is significant debate about the approach to cognitive assessment, given the limited sensitivity of screening tests in detecting mild cognitive impairment in highly functioning professionals, including doctors.

There are several tools identified in *Screening cognitive function in late career doctors* ([Part D: C-3](#)) that can be used as a starting point for screening cognitive function.

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<sup>92</sup> The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 9th edn, updated [Internet]. East Melbourne (Vic): RACGP, 2018 [cited 2024 Jun 12]. Available from: <https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Guidelines-for-preventive-activities-in-general-practice.pdf>



The main aims of cognitive screening are to establish a baseline for longitudinal comparison and to determine existing risk factors. When impairment in cognitive function is detected, the doctor should be referred to specialists for further testing and/or treatment. As is usual in any doctor-patient relationship, the assessing/treating doctor would provide ongoing support and information to the late career doctor.

#### *Role of the Board in relation to health checks*

An approved registration standard that requires late career doctors to have regular health checks would be the tool used to achieve the objectives of this option.

The general health check will be confidential between the late career doctor and their assessing/treating doctor. The Board would NOT receive information about any health issues identified in the checks and would NOT receive any results of the health check.

The late career doctor would be asked to declare in their annual registration renewal that they have completed the appropriate health check. As they do now, they would also need to declare whether they have an impairment that detrimentally affects, or is likely to detrimentally affect, their capacity to practise medicine.

The Board is not proposing to introduce general health checks as a punitive measure. Health checks are intended to enable doctors to make informed decisions about their health and practice and address health related problems early to avoid more serious impacts to themselves and their patients later.

Action to address identified health issues and/or return the late career doctor to safe practice whenever possible, would ideally be conducted at arms-length from the Board. There would be no requirement to report the outcome of the health check to the Board or Ahpra, unless the doctor has been found to pose a substantial risk to the public that is not being managed. [Mandatory reporting](#) is only likely to be necessary when unmanaged substantial risk is identified. Health check outcomes would not be used by the Board. When unaddressed health issues lead to substantial risk to patients, the Board may require a Board arranged [health assessment](#), (in line with existing provisions of the National Law) usually with an independent assessor.

#### *How this option will meet the policy objectives*

A general health check for late career doctors would enable individual doctors to make informed decisions about their health and practice and address health related problems early to avoid more serious impacts to themselves and their patients later.

## 4. What is the likely net benefit of each option?

The Board has considered the net benefit of each option and concluded:

- the research supports the Board taking additional action beyond existing regulatory requirements
- the potential overall costs of requiring a fitness to practice assessment are unreasonable relative to the benefits to the community
- requiring late career doctors to have a health check is informed by the evidence of declining performance and patient outcomes as a doctor ages and costs are outweighed by the benefits of encouraging doctors to take responsibility for their own health and the benefits to patients.

Cost-benefit analysis is used to assess regulatory proposals to encourage better decision making. The Board has evaluated the impacts of the options, accounting for all the effects on the community and economy, not just the immediate or direct effects, financial effects, or effects on one group. It emphasises, to the extent possible, valuing the gains and losses from a regulatory proposal in monetary terms. The Board has identified it is difficult to identify and measure the effects of some elements of the proposed regulation.

The Board has reviewed the net benefit of each of the three identified options.

### **Option 1: Rely on existing guidance (Status quo)**

#### **Regulatory impacts**

This option is the status quo which relies on existing guidance including the Board's Code of conduct and on the Board and others continuing to provide 'behavioural insights' that encourage late career doctors to seek independent medical advice and look after their own health.

This includes the Australian government who has recognised the importance of health assessments in older Australians by providing Medicare rebates for health checks for all Australians aged 75 years and older. Doctors aged 75 years and older have access to these Medicare items<sup>93</sup>, however there are many late career doctors who do not have these voluntary checks.

The Board has identified this option will have the least impact on practitioners, but it is likely to do little to address the problem that the Board has identified.

There would be no additional regulatory impacts or compliance costs for this option. Existing regulatory costs have not been identified.

<sup>93</sup> Department of Health and Aged Care. Health assessment for people aged 75 years and older [Internet]. Canberra (AU). Commonwealth of Australia [updated 2014 Apr 10; cited 2024 Jun 12] Available from: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare\\_mbsitem\\_75andolder](https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_75andolder)

## Social and economic impacts

	Benefits	Costs
<b>Consumers</b>	<ul style="list-style-type: none"> <li>no additional benefits identified</li> </ul>	<ul style="list-style-type: none"> <li>patient outcomes may be impacted by doctors who have not identified health issues</li> <li>potential exposure to risks and harm from late career doctors who had undiagnosed health issues</li> </ul>
<b>Late career doctors</b>	<ul style="list-style-type: none"> <li>no additional benefits identified</li> </ul>	<ul style="list-style-type: none"> <li>not all late career doctors will follow advice or guidance about looking after their own health</li> <li>there is a significant risk that relying on existing guidance will allow these doctors to continue to place their own health at risk and potentially place their patients at risk of harm if they are impaired and therefore unable to practise safely</li> <li>there is a loss of the opportunity to assist doctors who have health issues. Health management or changes to practice could mitigate risks to the public and support ongoing safe practice</li> <li>more serious impacts and preventable harms will not be avoided</li> </ul>
<b>Regulators</b>	<ul style="list-style-type: none"> <li>no additional benefits identified</li> </ul>	<ul style="list-style-type: none"> <li>increased costs to the Medical Board and co-regulatory bodies of regulating late career practitioners who continue to practise when impaired. These costs would not be incurred if the practitioner changed their practice or retired voluntarily</li> <li>the cost of damage to public confidence in the safety of health services and public protection</li> </ul>
<b>Government</b>	<ul style="list-style-type: none"> <li>no additional benefits identified</li> </ul>	<ul style="list-style-type: none"> <li>a reduction in public confidence about the safety of health services may lead to less consumers/patients seeking treatment or regular screening tests. This would impact on the severity of diseases experienced and increase medical treatment costs when they are eventually detected</li> </ul>
<b>Broader health sector</b>	<ul style="list-style-type: none"> <li>no additional benefits identified</li> </ul>	<ul style="list-style-type: none"> <li>ongoing costs of professional indemnity insurance with insurers continuing to represent doctors with health concerns who require regulatory action as a result of health concerns</li> <li>there is a higher risk of notifications (complaints) relating to physical or cognitive impairment of a late career doctor, even if they are highly experienced. That can result in additional responsibility on colleagues to deal with a practitioner whose health may be impacting public safety.</li> </ul>

## Conclusion

While it is difficult to quantify the costs to patients of sub-optimal care, which can range from delayed access to adequate care, through to catastrophic outcomes, the research supports the Board taking additional action beyond existing regulatory requirements, particularly because the current arrangements are not preventing impaired late career practitioners from practising.

The Board has previously published information for late career doctors in its monthly newsletter and on its website about the value of maintaining their own good health. The Board uses this 'behavioural insights' approach to attempt to 'nudge' doctors on a range of matters and this would continue. However, data indicate notifications continue to increase despite using these behavioural insights approaches.

The Board also funds independent doctors' health services in every state and territory to support medical practitioners and students. The free confidential advisory services provide ongoing advice and support to doctors who have concerns about their wellbeing, including stress, mental health questions, substance abuse, or physical health issues. They do not take the place of formal clinical care but can assist in helping doctors organise this as needed. These health services run at arms-length from the Board and actively promote that doctors have an independent GP.

Despite these approaches, there is an ongoing reluctance for some doctors to have their own GP. Therefore, the Board does not consider a 'nudge' could achieve the desired outcome of all late career doctors looking after their health without imposing new mandated requirements.

**Option 2: Require a detailed health assessment of the ‘fitness to practise’ of doctors aged 70 years and older**

**Regulatory impacts**

Fitness to practise assessments are usually performed by a specialist occupational and environmental physician or similarly qualified medical practitioner and include an independent clinical assessment of the current and future capacity of the doctor to practise in their particular specialty or scope of practice. For example, in addition to their general health check (option 3), they might also have an assessment of their dexterity, ability to stand for prolonged time, capacity to hear and/or see and give instructions.

These types of fitness to practise health assessments usually cost between \$1,500 and \$2,500.<sup>94</sup>

A cognitive function assessment may also be required to determine capacity for complex problem analysis and decision-making. Costs for cognitive assessment range from \$1,200 for a straight-forward cognitive assessment through to \$3,500 for a more comprehensive neuropsychological assessment.<sup>95</sup> These costs would be borne by the late career doctor, although this may be passed on by the doctor to their patients. The likely cost impact per late career doctor would be up to \$6,000, or \$115 per week.

In this section, we have calculated typical costs both with and without a cognitive assessment. Our calculations are based on data as of June 2023, where there were 6,975 doctors aged 70 years and over holding practising registration in Australia, with 5,940 aged between 70 and 79 years and 1,035 aged 80 years and over.

Compliance costs for the individual doctors are expected to be between \$4.52 million and \$7.54 million per year for a ‘fitness to practise’ assessment (without cognitive assessment). If cognitive assessments were included, costs are likely to increase to between \$8.14 million and \$18.09 million. Additionally, around 9,000 hours of late career doctors’ time, costed at \$1.36 million would be incurred. The cost for each doctor is spread across doctors in each age group as follows:

Doctors aged 70 to 79 years	Doctors aged 80 years and older
<b>Once every three years</b>	<b>Every year</b>
<ul style="list-style-type: none"> <li>time commitment of two to four hours to undergo the fitness to practise assessment and cognitive assessment</li> <li>‘fitness to practise’ assessment cost of between \$1,500 and \$2,500</li> <li>cognitive assessment cost of between \$1,200 and \$3,500</li> </ul>	<ul style="list-style-type: none"> <li>time commitment of two to four hours to undergo the fitness to practise assessment and cognitive assessment</li> <li>‘fitness to practise’ assessment cost of between \$1,500 and \$2,500</li> <li>cognitive assessment cost of between \$1,200 and \$3,500</li> </ul>

<sup>94</sup> Fees calculated based on advice from The Australian and New Zealand Society of Occupational Medicine. Fee for 60min consultation plus preparation and report = \$1,500. 90min consultation plus preparation and report = \$2,500.

<sup>95</sup> Fees calculated from individual psychological services and the Australian Psychological Society. [https://www.mindsinmotion.com.au/contact\\_fees.htm#:~:text=A%20comprehensive%20assessment%20will%20usually,de pending%20on%20the%20time%20taken](https://www.mindsinmotion.com.au/contact_fees.htm#:~:text=A%20comprehensive%20assessment%20will%20usually,de pending%20on%20the%20time%20taken); <http://sydneyneuropsych.com.au/about-us/neuropsychology-fees/>



## Education

*Late career doctors* would need to become aware of the Board's requirements before renewal of registration. This would be through targeted emails and general information provided to doctors. It is envisaged this would take approximately five minutes for each doctor to read and is therefore included in the time commitment above.

*Doctors conducting the fitness to practise assessments (assessing/treating doctor)* would need to be qualified to conduct the assessments. As there are less than 300 registered specialist occupational and environmental physicians in Australia, it is likely there would be significant workload pressures placed on the trained specialist occupational physicians or similarly qualified medical practitioners as they complete the estimated 3,015 detailed assessments each year.

While the assessing/treating doctors would not require training to conduct a fitness to practise assessment, they would need to familiarise themselves with the Board's requirements for the fitness to practise assessments. This may take between one to two hours but would be able to be claimed by the doctor as part of their CPD requirements.

*Ahpra staff* would need to become familiar with the requirements. This is part of the core business of Ahpra, therefore there are no additional costs.

## Purchasing

*Assessing/treating doctors* may decide to upgrade their practice software to specifically include the requirements of the fitness to practise assessment, however existing software would be suitable.

## Record keeping

*Late career doctors* would need to keep evidence from their doctor that they have had a fitness to practise assessment. The evidence is similar to a medical certificate and would not result in any additional costs to the doctor.

*Assessing/treating doctors* would keep records of the fitness to practise assessment as part of their regular practice of record keeping. No additional records would need to be kept.

## Enforcement

*Late career doctors* may be audited by Ahpra to confirm they have complied with the registration standard. This would be conducted as part of the existing audit process. It is envisaged the doctor would need to provide evidence from their doctor that they have had a fitness to practise assessment. This is similar to the doctor providing a medical certificate. The results of the fitness to practise assessment would not need to be provided. There is no additional cost as this is part of existing auditing arrangements.

*Assessing/treating doctors* may be required to confirm the late career doctor has had a fitness to practise assessment if the late career doctor is audited and cannot produce evidence. The results of the assessment do not need to be provided.

## Regulatory burden estimate (RBE) table

Average annual regulatory costs					
Change in costs (\$ million)/year	Individuals (Low end)	Individuals (High end)	Business	Community organisations	Total change in cost/year
	\$m	\$m	\$m	\$m	\$m
Fitness to practise assessment	4.52	7.54	0	0	4.52 – 7.54
Cognitive assessment	3.62	10.55	0	0	3.62 – 10.55
Time	1.36	1.36	0	0	1.36
Other regulatory costs	Not assessed	Not assessed	Not assessed	0	Not assessed
<b>Total, by sector</b>	<b>5.88</b> (no cognitive assessment)	<b>19.45</b>	<b>0</b>	<b>0</b>	<b>5.88 – 19.45</b>

Note: All costs for the late career doctors have been allocated to individuals. Although many doctors work for, or own, corporations, as this option directly affects doctors as individual registrants and numbers of doctors can be accurately counted using registration data, the costs have been allocated to individuals.

### Social and economic impacts

The key benefits and costs associated with Option 2 are set out in the table below.

If the Board required a detailed fitness to practise examination of doctors aged 70 years of age and older to assess the ability of each practitioner to practise medicine within their specialty/scope of practice, the compliance costs would be significantly higher than for a general health check.

The main costs of this option are the economic costs indicated above, ranging from \$5.88 million - \$19.45 million per year. Costs are high because the assessments would be lengthy and would likely require highly specialised testing that in turn would require training and credentialing of assessing doctors and payment for using some cognitive testing resources.



	Benefits	Costs
<b>Consumers</b>	<ul style="list-style-type: none"> <li>• support safe, ongoing medical services within Australian communities</li> <li>• potential for reduced exposure to risks and harm from late career doctors who had undiagnosed health issues</li> <li>• would improve consumer access to doctors who can be assured they are providing safe care</li> <li>• likely increased satisfaction with outcomes of medical consultations and potential for fewer medical errors, disputes and/or litigation</li> <li>• maintains the balance between supporting high quality health care for patients while minimising the impact on doctors</li> </ul>	<ul style="list-style-type: none"> <li>• it is possible late career doctors may pass on assessment costs to patients, although this would be a very small amount per patient</li> <li>• a small number of doctors may have health conditions detected that would lead to a change in their practice arrangements, and occasionally their ceasing to practise. There may be a small number of occasions where this would impact on the availability of doctors in particular regions, however, it is difficult to specifically attribute this to the outcomes of a fitness to practise assessment compared with the general propensity to retire with increasing age</li> </ul>
<b>Late career doctors</b>	<ul style="list-style-type: none"> <li>• would ensure late career doctors are fit to practise medicine</li> <li>• would contribute to supporting late career doctors to achieve optimum outcomes for their patients</li> <li>• doctors may benefit from increased consumer confidence in late career doctors</li> <li>• may help to normalise conversations about doctors' health and ensure late career doctors are managing any potential health concerns that may impact on their practice</li> <li>• would ensure that late career doctors, in partnership with their assessing/treating doctor, retain control of their health care and their practice</li> </ul>	<ul style="list-style-type: none"> <li>• some doctors may have health conditions detected that would lead to a change in their practice arrangements, and occasionally their ceasing to practise</li> <li>• there may be a social cost to late career doctors feeling offended that their professionalism is undermined if they are required to undergo regular fitness to practise health assessments</li> <li>• there may be additional impacts on doctors working part-time if they felt discouraged from remaining in practice because they feel a fitness to practise assessment is burdensome</li> </ul>

	Benefits	Costs
<b>Assessing/treating doctors</b>	<ul style="list-style-type: none"> <li>• help to normalise conversations about doctors' health</li> <li>• ensure that late career doctors in partnership with their assessing/treating doctor retain control of their health care and their practice</li> </ul>	<ul style="list-style-type: none"> <li>• there is likely to be additional workload pressure placed on the occupational physicians undertaking the assessments as there are less than 300 registered specialist occupational and environmental physicians in Australia, the vast majority of these being based in metropolitan areas</li> <li>• doctors undertaking the fitness to practise assessments would need to familiarise themselves with the Board's requirements</li> </ul>
<b>Regulators</b>	<ul style="list-style-type: none"> <li>• builds on current expectations of good medical practice as described in the Board's <i>Code of conduct</i></li> <li>• regulators will be more able to be assured that registrants' ability to practise is not affected by health conditions</li> <li>• public expectations for safe care will be better met</li> <li>• enhanced public confidence in the National Scheme</li> <li>• regulators have existing approaches that can be used to monitor compliance in an efficient manner</li> </ul>	<ul style="list-style-type: none"> <li>• there are likely to be some implementation costs for the Board/Ahpra associated with monitoring and enforcing fitness to practise assessments. These costs are expected to be small<sup>96</sup></li> <li>• it may cost more to deal with the impaired practitioners who might be reported</li> <li>• it is likely there would be costs for developing and maintaining clinical assessment resources relevant to each medical speciality and scope of practice, to ensure consistency across assessments. This cost has not been assessed as specialist medical colleges and other experts in each speciality would need to assess the existing speciality training resources and adapt these to fitness to practise expectations</li> </ul>
<b>Governments</b>	<ul style="list-style-type: none"> <li>• public confidence in the safety of health services and public protection is likely to be enhanced</li> </ul>	<ul style="list-style-type: none"> <li>• there may be a small impact on government policies regarding the medical practitioner workforce if some doctors are assessed as not fit to practise which would lead to a change in their practice arrangements, and occasionally their ceasing to practise</li> </ul>

<sup>96</sup> Ahpra has advised that additional compliance activity will be supported through existing resourcing.

	Benefits	Costs
<b>Broader health sector</b>	<ul style="list-style-type: none"> <li>the impact of impaired doctors may extend more broadly to the health team who work to compensate for the practitioner's deficiencies to keep patients safe. The identification and management of practitioners who are impaired is likely to be beneficial to their colleagues</li> <li>promote a culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and wellbeing. This could extend beyond medicine to health more generally</li> <li>enable safe, ongoing medical services within Australian communities which would benefit all patients consulting late career doctors</li> </ul>	<ul style="list-style-type: none"> <li>there may be a small number of occasions where this would impact on the availability of doctors in particular regions, however, it is difficult to specifically attribute this to the outcomes of a fitness to practise assessment, compared with the general propensity to retire with increasing age</li> <li>potential for other medical practitioners to feel that this action of the Board represents regulatory overreach</li> </ul>

### Conclusion

This is a medium to high-impact option. It would be very costly for the late career practitioner and while intuitively it appears to be the most protective approach for the community, the Board does not have evidence that it is a necessary intervention.

A potential downside of this option is that late career doctors may find a requirement for regular fitness to practise health assessments undermines their professionalism.

The Board believes the potential overall costs are likely unreasonable relative to the possible benefits to the community.

### Option 3: Require general health checks for late career doctors

#### Regulatory impacts

Option 3 is to require doctors aged 70 years and older to undergo general health checks every three years, and yearly from 80 years of age. The checks would usually be completed by the late career doctor's regular GP.

The funding of medical services is very complex in Australia. Doctors set their own fees and there is no uniform approach to billing by doctors. We have therefore adopted typical ranges by using the Medicare billing rates at the lower end and the AMA scheduled fees at the higher end. The actual costs would be expected to be somewhere within that range.

At the lower end, some assessing doctors might limit their charges to the Medicare Benefits Schedule (MBS) for health assessments which is between \$209.45 and \$295.90 for a long or prolonged consultation necessary to complete a health check.<sup>97</sup> If all assessing doctors were to charge the MBS rate (which is unlikely), the cost of a health check for doctors aged between 70 and 79 years of age every three years (and yearly for doctors aged 80 years and older) would be between \$631,492 and \$892,139 annually.

At the higher end, if assessing doctors decided to charge according to the AMA schedule, the recommended cost is between \$455 and \$570 for long or prolonged health checks.<sup>98</sup> If all assessing doctors were to charge the AMA rate (which is also not likely), the cost of a health check for doctors 70 and older every three years (and yearly for doctors aged 80 years and older) would be between \$1,371,825 and \$1,718,550 per annum.

Costs would ultimately depend on how assessing doctors decided to bill for the consultation. We have therefore quantified ranges, with assumptions included.

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<sup>97</sup> [Medicare Benefits Schedule – Items 705 and 707](#)

705: Professional attendance by a general practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes. Fee: \$209.45 Benefit: 100% = \$209.45

707: Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes). Fee: \$295.90 Benefit: 100% = \$295.90

Consultation including:

- (a) comprehensive information collection, including taking a patient history; and
- (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and
- (c) initiating interventions or referrals as indicated; and
- (d) providing a comprehensive preventive health care management plan for the patient.

<sup>98</sup> Australian Medical Association: Schedule of recommended fees.

Attendance by general practitioner to undertake a **long health check (AA503)**, including:

- a) comprehensive information collection, including taking a patient history;
- b) an extensive examination of the patient's medical condition and physical function;
- c) initiating interventions and/or referrals as indicated; and
- d) providing a basic preventive health care management plan. Recommended fee: \$455.00

Attendance by general practitioner to undertake a prolonged health check (AA504), including:

- a) comprehensive information collection, including taking a patient history;
- b) an extensive examination of the patient's medical condition and physical, psychological and social function;
- c) initiating interventions and/or referrals as indicated; and
- d) providing a comprehensive preventive health care management plan. Recommended fee: \$570.00

## Costs to doctors

Compliance costs for individual doctors are therefore expected to be:

Doctors aged 70 to 79 years	Doctors aged 80 years and older
<b>Once every three years</b>	<b>Every year</b>
<ul style="list-style-type: none"> <li>a time commitment of two hours away from their clinical practice every three years to undergo the health check</li> <li>payment once every three years for the health check of between \$209.45 and \$295.90 (MBS rebate) and \$455 and \$570 (AMA recommended fees)</li> </ul>	<ul style="list-style-type: none"> <li>a time commitment of two hours per year to undergo the health check</li> <li>a yearly payment for the health check of between \$209.45 and \$295.90 (MBS rebate) and \$455 and \$570 (AMA recommended fees)</li> </ul>

The details of these calculations are:

Option 3: Health check every three years for doctors aged between 70 – 79 years and yearly for doctors 80 years and older	
Numbers of doctors	Calculations
5,940 doctors aged 70-79 years (3 yearly check) = 1,980 doctors each year  + 1,035 doctors aged 80 years and older (yearly check)  Total assessments each year = 3,015	<p><b>5,940 doctors aged 70-79 years</b> /3 = 1,980</p> <p>MBS rates:            \$209.45 x 1,980 = \$414,711            \$295.90 x 1,980 = \$585,882</p> <p>AMA recommended fees:            \$455 x 1,980 = \$900,900            \$570 x 1,980 = \$1,128,600</p> <p><b>plus</b>  <b>1,035 doctors aged 80+</b></p> <p>MBS rates:            \$209.45 x 1,035 = \$216,781            \$295.90 x 1,035 = \$306,257</p> <p>AMA recommended fees:            \$455 x 1,035 = \$470,925            \$570 x 1,035 = \$589,950</p> <p><b>Total cost of:</b></p> <p>MBS rates:            \$209.45 x 3,015 = \$631,492            \$295.90 x 3,015 = \$892,139</p> <p>AMA recommended fees:            \$455 x 3,015 = \$1,371,825            \$570 x 3,015 = \$1,718,550</p>
<b>Time commitment (per year)</b>	<p>Late career doctor:            2 hours @ \$150 per hour            \$150x 2 hours x 3,015 doctors = \$904,500</p> <p>Doctor/s conducting the health check:            2 hours x 3,015 checks = 6,030 hours            Cost included in health check calculation above</p>

Note: Costs for option 3 may be reduced for doctors who have had the Medicare funded health assessment for over 75 year old Australians.

## Other compliance costs

### Administrative

The late career doctor would need to report their compliance to the Board during the annual registration renewal process by answering one additional question likely to be 'If you are aged 70 years or older, have you had a health check in the past three years (or yearly for 80 years and older), as required in the (draft) *Registration standard: Health checks for late career doctors*'. It is envisaged this would take under one minute to answer and is therefore included in the time commitment above.

*Doctors conducting the health checks (assessing/treating doctor)* may need to provide information (notification) to Ahpra if they have a reasonable belief that the late career doctor is placing the public at substantial risk of harm by practising the profession while the practitioner has an impairment. It is envisaged this number would be very small and has therefore not been costed.

*Ahpra/the Board* would need to refer the registration standard to Health Ministers for approval and notify late career doctors and stakeholders about the requirements. This is part of the core business of Ahpra, therefore there are no additional costs.

### Education

*Late career doctors* would need to become aware of the Board's requirements before renewal of registration. This would be through targeted emails and general information provided to doctors through the regular newsletter of the Board. It is envisaged this would take approximately five minutes for each doctor to read and is therefore included in the time commitment above.

*Doctors conducting the health checks (assessing/treating doctor)* would need to familiarise themselves with the Board's requirements for the health checks. The requirements are straight-forward, and part of routine medical practice so should not be time consuming. Documentation has been prepared that will support the doctor conducting the health check to work through the requirements.

*Ahpra/the Board* would need to communicate the new requirements to internal staff. It would also need to communicate with other stakeholders. As this is part of the core business of Ahpra, no additional costs have been calculated.

### Purchasing

It is unlikely that doctors conducting the health checks (assessing/treating doctor) will need to upgrade their practice software to include the requirements of the health checks. Therefore, there are no additional costs.

### Record keeping

The late career doctor would need to keep evidence from their doctor that they have had a health check. The evidence is similar to a medical certificate and would not result in any additional costs to the doctor.

Doctors conducting the health checks (assessing/treating doctor) would keep records of the health check, but this is a part of their regular practice of record keeping. No additional records need to be kept.

### Enforcement

The late career doctor may be audited by Ahpra to confirm they have complied with the registration standard. This would be conducted as part of the existing audit process. It is envisaged the late career doctor would need to provide evidence from their treating doctor that they have had a health check. This would be a certificate that was provided to the late career doctor at the time of the health check. The Board will not require results of the health check to be provided as part of compliance audits.

Doctors conducting the health checks (assessing/treating doctor) may be required to confirm the late career doctor has had a health check if the late career doctor is audited and cannot produce evidence. The results of the health check do not need to be provided.

Ahpra/the Board would need to audit compliance with the registration standard. There is no additional cost as this would occur as part of existing auditing arrangements.

### Regulatory burden estimate (RBE) table

Average annual regulatory costs					
Change in costs (\$ million)	Individuals (Low end)	Individuals (High end)	Business	Community organisations	Total change in cost
	\$m	\$m	\$m	\$m	\$m
Health check	0.63	1.72	0	0	0.63 – 1.72
Time	0.9	0.9	0	0	0.9
Other regulatory costs	0	0	0	0	0
<b>Total, by sector</b>	<b>1.53</b>	<b>2.62</b>	<b>0</b>	<b>0</b>	<b>1.53 – 2.62</b>

Note: All costs for the late career doctors have been allocated to individuals. Although many doctors work for, or own corporations, as this option directly affects doctors as individual registrants and numbers of doctors can be accurately counted using registration data, the costs have been allocated to individuals.

### Social and economic impacts

The key benefits and costs associated with Option 3 are set out in the table below.

If the Board required a health check for doctors aged 70 years of age and older, the compliance costs would be significantly lower than for a fitness to practise health assessment. The main costs of this option are the economic costs indicated above, ranging from \$1.53 – 2.62 million per year. In reality, they are likely to be less than this because some practitioners would be having a similar health check regardless of the Board's requirement.

	Benefits	Costs
<b>Consumers</b>	<ul style="list-style-type: none"> <li>reduced exposure to risk and harm from late career doctors who had undiagnosed health issues. This would result in safer individual health care because consulting doctors are less likely to be affected by health issues</li> <li>increased patient satisfaction with outcomes of medical consultations and potential for fewer disputes and/or litigation</li> </ul>	<ul style="list-style-type: none"> <li>some doctors may have health conditions detected that would lead to a change in their practice arrangements, and occasionally their ceasing to practise. There may be a small number of occasions where this would impact on the availability of doctors in particular regions, however, it is difficult to specifically attribute this to the outcomes of a health check, compared with the general</li> </ul>

	Benefits	Costs
	<ul style="list-style-type: none"> <li>greater confidence in the medical profession</li> </ul>	<ul style="list-style-type: none"> <li>propensity to retire with increasing age</li> </ul>
<b>Late career doctors</b>	<ul style="list-style-type: none"> <li>improved culture within medicine to support practitioners to identify and manage health concerns early</li> <li>improved health outcomes for late career doctors through early intervention and management of health concerns</li> <li>reduced rates of notification for older practitioners with potential for regulatory action including forced retirement</li> </ul>	<ul style="list-style-type: none"> <li>some doctors may have health conditions detected that would lead to a change in their practice arrangements, and occasionally their ceasing to practise</li> <li>some late career doctors may feel offended and that their professionalism is undermined if they are required to undergo mandatory regular health checks</li> <li>some late career doctors in rural and remote areas of Australia may not have access to a GP, however, there are outreach visiting doctor services in rural areas for rural and remote health practitioners and telehealth may be available for some parts of the health check</li> </ul>
<b>Assessing/ treating doctors</b>	<ul style="list-style-type: none"> <li>help to normalise conversations about doctors' health</li> <li>ensure that late career doctors in partnership with their assessing/ treating doctor retain control of their health care and their practice</li> </ul>	<ul style="list-style-type: none"> <li>doctors undertaking the health checks would need to familiarise themselves with the Board's requirements</li> </ul>
<b>Regulators</b>	<ul style="list-style-type: none"> <li>builds on current expectations of good medical practice as described in the Board's Code of conduct</li> <li>will give regulators an additional tool to set a standard for patient safety and to support monitoring of compliance with the standard</li> <li>the Board may receive a notification from a treating practitioner if they detect during the health check that a late career doctor is impaired but is unwilling to take voluntary action. This will give the Board the opportunity to take protective action</li> <li>improved public confidence in the regulator who is seen to be proactive in ensuring safe practice</li> <li>as registration standards are an existing mechanism, the Board/Ahpra has existing approaches that can be used to</li> </ul>	<ul style="list-style-type: none"> <li>there may be some implementation costs for the Board/Ahpra associated with the health checks. Ahpra has advised that additional compliance activity will be supported through existing resourcing</li> </ul>



	Benefits	Costs
	monitor compliance in an efficient manner	
<b>Governments</b>	<ul style="list-style-type: none"> <li>public confidence in the safety of health services and public protection is likely to be enhanced</li> </ul>	<ul style="list-style-type: none"> <li>there may be a small impact on government policies regarding the medical practitioner workforce if some doctors have health conditions detected that would lead to a change in their practice arrangements, and occasionally their ceasing to practise</li> </ul>
<b>Broader health sector</b>	<ul style="list-style-type: none"> <li>generally, it would help to raise clinical standards and safety by actively identifying and managing impaired practitioners. This will result in a positive impact for the health sector</li> <li>enable safe, ongoing medical services within Australian communities which would benefit all patients consulting late career doctors</li> <li>help to normalise conversations about doctors' health and promote a positive culture of medicine and more broadly, in health care. May contribute to other professions also working towards more proactive management of health</li> <li>helps to deal with concerns when others in the broader health sector can see that a medical practitioner's health may be impaired. Identification and management of practitioners who have health issues is likely to be beneficial to their colleagues in the health team who may be working to compensate for the practitioner's deficiencies to keep patients safe</li> </ul>	<ul style="list-style-type: none"> <li>there may be a small number of occasions where this would impact on the availability of doctors in particular regions, however, it is difficult to specifically attribute this to the outcomes of a health check, compared with the general propensity to retire with increasing age</li> </ul>

### Conclusion

The Board has considered the potential overall costs of this option, relative to the benefits to the community of assuring that late career doctors can continue to provide safe care to their patients. The Board believes this option is justified and not onerous or costly. The total economic cost is projected to be between \$1.53 and \$2.62 million per year. The major cost is likely to be the social or emotional cost to some late career doctors who may feel offended and that their professionalism is undermined if they are required to undergo mandatory regular health checks. Overall, the Board considers the cost is outweighed by the benefits of encouraging doctors to take responsibility for their own health and the benefits to patients. The proposal is informed by the evidence of declining performance and patient outcomes as a doctor ages.

## Questions for consideration

The Board is considering three options to assure 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-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?
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?
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.

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?
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 practise medicine safely.
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?
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?
  - 7.2. Is there anything missing that needs to be added to the draft registration standard?
  - 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?
- 8.2. What changes would improve them?
- 8.3. Is the information required in the medical history (C-1) appropriate?
- 8.4. Are the proposed examinations and tools listed in the examination guide (C-2) appropriate?
- 8.5. Are there other resources needed to support the health checks?

## 5. Who was consulted and was their feedback incorporated?

### Background

This paper meets the consultation requirements of the National Law and the Australian Government OIA requirements for a CRIS.

The Board is one of 15 National Boards in the National Scheme. The National Scheme is governed by the National Law. The relevant sections of the National Law for considering this proposal are sections 35, 38, 39, 40, 41 and 109.

The Board's functions include registering medical practitioners and medical students, developing registration standards, codes and guidelines for the medical profession, and managing notifications about the health, conduct or performance of medical practitioners. Under the National Law, protection of the public is the paramount guiding principle for everything the Board does. The National Law empowers the Board to develop registration standards about the suitability of individuals to competently and safely practise the profession and propose these standards to Health Ministers for approval.

Any registration standards, codes and guidelines developed by the Board for the medical profession must comply with the National Law and be prepared in accordance with Ahpra's *Procedures for development of registration standards, codes and guidelines* and the *OIA Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies*.

If a National Board proposes a new standard, code or guideline, the National Law requires that the Board must ensure there is wide-ranging consultation on the content of the proposal.

If a proposal from a National Board has a potentially more than minor impact on business or the community, the OIA advises that a Regulatory Impact Analysis is needed. Undertaking a regulatory impact analysis ensures that the Board analyses the costs and benefits when considering options which have a regulatory impact.

### Public consultation

The OIA has advised a CRIS is required for the proposal to require late career doctors to have regular health checks. This CRIS has been developed in consultation with the OIA and provides a summary of the Board's assessment of the impact and cost-benefit analysis of options in relation to health checks for late career doctors.

The Board is undertaking public consultation to seek feedback from a wide range of stakeholders to help the Board better assess the extent of the problem, the potential impacts of the proposed options, and the most appropriate response. Any response needs to be proportionate and balance reasonable requirements for late career doctors to monitor their health and address issues which may affect their capacity to safely provide medical care to their patients.

This paper compares three non-regulatory and regulatory options:

- Option 1 Rely on existing guidance (Status quo)
- Option 2 Require detailed health assessment of the 'fitness to practise' of doctors aged 70 years and older
- Option 3 Require a general health check for late career doctors

The consultation is open to all stakeholders and individuals who may have an interest in the policy question and the potential regulatory requirements. Stakeholders include:

- state and territory health departments
- specialist medical colleges
- Council of Presidents of Medical Colleges (CPMC)
- Australian Medical Association (AMA)
- Australian Indigenous Doctors' Association (AIDA)
- other medical regulators
- professional associations
- professional indemnity insurers
- consumer organisations
- Aboriginal and Torres Strait Islander Peoples organisations
- other National Boards
- health complaints entities
- individual doctors
- other health practitioners, including nurses and nurse practitioners, dentists, allied health practitioners
- administrative and managerial staff working with doctors
- patients/community members.

Stakeholders will be informed about the consultation through existing channels, including the Board's monthly newsletter, publishing media releases, medical media stories and social media. Feedback received from this consultation will be incorporated into a Decision RIS that informs the decision whether to proceed with one of the proposed options.

### Previous consultation

#### **Targeted preliminary consultation on the proposed options to address late career doctors' health**

The Board undertook targeted consultation with key stakeholders in February to April 2021 to test a range of proposed options described in this Consultation RIS. Stakeholders including state and territory health departments, specialist medical colleges, medical professional associations, professional indemnity insurance providers and consumer groups were briefed by the Chair of the Board via a webinar on 23 February 2021 and then provided with a preliminary consultation paper. There was broad support for option three in the responses received and an analysis of the responses was provided to the Board. This analysis of the stakeholder views has informed this impact analysis and options for consultation.

Key stakeholders supported the content and structure of the proposed registration standard, particularly that the health check results remain confidential and at arms-length from the Board. However, there was some confusion about the difference between a general health check and a 'fitness to practise' assessment. Further work has been done to accurately explain the differences.

There was overwhelming support that late career doctors should have a health check that includes some screening assessment of cognitive function, with suggestions that information in the supporting documents should identify referral and further testing options.

Almost all submissions supported the proposed timeframe of three yearly checks from 70 and yearly from 80 years of age. Some stakeholders proposed the health checks should occur more frequently

and/or commence at 65 years of age, although the Board has decided to consult more widely on the starting age and the most appropriate interval between checks.

Some feedback identified potential challenges for doctors based in rural and remote locations. Guidance materials would be developed highlighting how telehealth could be used to conduct parts of the health check, with support from local health practitioners.

In addition to any changes to the proposed registration standard, guidance material has been developed. These materials also formed part of the preliminary consultation and are also included in the CRIS for public consultation.

### Previous options and consultation

The Board established an Expert Advisory Group (EAG) in 2016 to develop a practical and effective pathway that will help keep doctors competent and up to date throughout their working lives. The EAG released an interim report on 16 August 2016 that proposed a two-part approach consisting of:<sup>99</sup>

- maintaining and enhancing the performance of all doctors practising in Australia through efficient, effective, contemporary, evidence based CPD relevant to their scope of practice ('strengthened CPD'), and
- options for proactively identifying doctors at risk of poor performance and those who are already performing poorly, assessing their performance and when appropriate supporting the remediation of their practice. Late career doctors were identified as a group of at-risk doctors.

The Board undertook wide-ranging consultation on the EAG's proposal over three and a half months. During the consultation, hundreds of doctors, their representatives, community members and educators shared their ideas and feedback on the proposal put forward by the EAG on what we should do to build a system for revalidation in Australia that is tailored to our health care context, and is practical, effective and evidence based.

During the consultation the Board:

- received 116 submissions (published online)<sup>100</sup>
- met with all specialist medical colleges, the CPMC and the AMA
- held forums in each state and territory, attended by more than 400 stakeholders
- heard from more than 1,000 doctors and community members in an online discussion forum<sup>101</sup> and an online survey
- met three times with the Board's Consultative Committee established to provide feedback on issues related to the introduction of revalidation in Australia
- published a perspective from (the then) Medical Board Chair, Dr Joanna Flynn, on revalidation,<sup>102</sup> along with a podcast<sup>103</sup> in the *Medical Journal of Australia* (MJA).

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<sup>99</sup> Medical Board of Australia. Expert advisory group on revalidation, 'Interim report on options for revalidation in Australia' [Internet], Melbourne (AU): MBA. 2016 [cited 2024 Jun 12]. Available from: <https://www.medicalboard.gov.au/documents/default.aspx?record=WD16%2F21167&dbid=AP&chksum=TTx9yoMyFewUiGseHXbJlg%3D%3D>

<sup>100</sup> Medical Board of Australia. Consultation on revalidation [Internet]. Melbourne (AU): MBA. 2016 Aug [cited 2024 Jun 12]. Available from: <https://www.medicalboard.gov.au/News/Past-Consultations/Consultations-August-2016.aspx>

<sup>101</sup> Medical Board of Australia. Consultation on revalidation [Internet]. Melbourne (AU): MBA. 2016 Aug [cited 2024 Jun 12]. Available from: <https://www.medicalboard.gov.au/News/Past-Consultations/Consultations-August-2016.aspx>

<sup>102</sup> J. Flynn, 'Towards revalidation in Australia: a discussion', *Med J Aust* [Internet], 2017 Jan 16 [cited 2024 Jun 12]; 206:7-8. Available from: <https://onlinelibrary.wiley.com/doi/10.5694/mja16.01162>

<sup>103</sup> J. Flynn, 'Towards revalidation in Australia', Perspective, [podcast], MJA Podcasts, 2017, Episode 1, [www.mja.com.au/podcasts](http://www.mja.com.au/podcasts)

Following the consultation, the EAG analysed the submissions and other feedback from the consultation process. The EAG met on several occasions to review the submissions and comments and finalise its recommendations. The final report of the EAG is published on the Board's website.<sup>104</sup>

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<sup>104</sup> Medical Board of Australia. Expert advisory group on revalidation, Final Report. [Internet], Melbourne (AU): MBA. 2017 Aug [cited 2024 Jun 12]. Available from: <https://www.medicalboard.gov.au/documents/default.aspx?record=WD17%2f24295&dbid=AP&chksum=Txmn8C7v%2bC53Wjsz3sXn2w%3d%3d>

## 6. What is the best option from those considered and how will it be implemented?

The Board has procedures it will follow if, following this consultation, it decides to proceed with one of the proposed options or an alternative option.

### Implementation

If the Board decides regulatory action is necessary to address the issues of declining health in late career doctors, a registration standard to require health checks or fitness to practice assessments will be the preferred regulatory mechanism. The Board would recommend a registration standard to Health Ministers, which if approved, the Board would widely publicise the new requirements. Clinical guidance outlining what would be involved in the health check/ fitness to practise assessment would also be provided to support implementation. Drafts of guidance to support Option 3 is provided in Appendix C.

Late career doctors and the general practitioners who would undertake the health checks or fitness to practice assessment (assessing/treating doctors) would be provided with information about the Board's requirements.

It is expected some late career doctors will oppose the requirements, preferring to manage their own health rather than being required to meet the requirements of the Board. However, as has been raised in this document, many doctors are reluctant patients, and the Board is concerned that doctors do not always seek the care they need. This is a particular issue for late career doctors, given that health challenges escalate with age. There is also strong evidence that there is a decline in performance and patient outcomes with increasing practitioner age, even when the practitioner is highly experienced.

As GPs are already conducting health checks for older members of the general public through the Medicare rebatable health assessments for people over 75 years of age, education is not required for the assessing/treating doctors, but they may need reassurance about the limits of their role.

### Transition

A transition period will be proposed, should the Ministerial Council approve a registration standard. The transition period would align with the registration period for most medical practitioners which is 1 October to 30 September each year and will give time for the Board to publicise requirements and give practitioners the time to have their health checks/fitness to practise assessments.

During the first year of the operation of the registration standard (if approved), it is proposed health checks/ fitness to practise assessments would occur for doctors at the age of 70 or 71 years; 73 or 74 years; 76 or 77 years; and all doctors aged 79 years and older. This is specified in the draft registration standard.

### Review

The Board regularly reviews its registration standards, generally every five years. Reviewing standards involves preliminary and public consultation to assess the stakeholder, doctor, and consumer opinion of how the standard has been operating and proposed changes to it.



# PART D: APPENDICES

## Appendix A:

# Patient and Consumer Health and Safety Impact Statement

12 June 2024

### Statement purpose

The Medical Board of Australia's (the Board) Patient and Consumer Health and Safety Impact Statement (Statement)<sup>105</sup> explains the potential impacts of a proposed registration standard, code or guideline on the health and safety of the public, vulnerable members of the community and Aboriginal and Torres Strait Islander Peoples.

The four key components considered in the Statement are:

1. The potential impact of the proposed health checks for late career doctors registration standard on the health and safety of patients and consumers particularly vulnerable members of the community including approaches to mitigate any potential negative or unintended effects
2. The potential impact of the proposed health checks for late career doctors registration standard, on the health and safety of Aboriginal and Torres Strait Islander Peoples including approaches to mitigate any potential negative or unintended effects
3. Engagement with patients and consumers, particularly vulnerable members of the community about the proposal
4. Engagement with Aboriginal and Torres Strait Islander Peoples about the proposal.

The National Boards' Health and Safety Impact Statement aligns with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025, National Scheme engagement strategy 2020-2025, the National Scheme Strategy 2020-25 and reflect key aspects of the revised consultation process in the Ahpra Board *Procedures for developing registration standards, codes and guidelines and accreditation standards*.

Below is the Board's initial assessment. This statement will be updated after consultation feedback.

### **1. How will this proposal impact on patient and consumer health and safety, particularly vulnerable members of the community? Will the impact be different for vulnerable members compared to the general public?**

The Board has carefully considered the impact that introducing health checks for late career doctors could have on patient and consumer health and safety, particularly vulnerable members of the community in order to put forward for consultation what is likely to be the best option.

The proposed option is based on best available evidence. Active assurance of safe practice is crucial to patient safety and quality clinical performance. The Board's proposal to require late career doctors to undergo a broad-based health check that is conducted every three years for doctors aged 70 to 79

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<sup>105</sup> This statement has been developed by Ahpra and the National Boards in accordance with section 25(c) and 35(c) of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law). Section 25(c) requires Ahpra to establish procedures for ensuring that the National Registration and Accreditation Scheme (the National Scheme) operates in accordance with good regulatory practice. Section 35(c) assigns the National Boards functions to develop or approve standards, codes and guidelines for the health profession including the development of registration standards for approval by the Ministerial Council and that provide guidance to health practitioners registered in the profession. Section 40 of the National Law requires National Boards to ensure that there is wide-ranging consultation during the development of a registration standard, code, or guideline.

years and every year for doctors aged 80 years and older will contribute significantly to this assurance and the National Scheme's objective of protecting the public.

The impact for vulnerable members is likely to be the same as for the general public or potentially greater if vulnerable communities are reliant on late career practitioners for their health care. If this proposal is approved, vulnerable communities can be assured that their doctor's health is not likely to be impacting negatively on the care they provide.

## **2. How will consultation engage with patients and consumers, particularly vulnerable members of the community?**

In line with our consultation processes the Board is undertaking wide-ranging consultation.

The Board is engaging with patients and consumers, peak bodies, communities and other relevant organisations during public consultation to get input and views from organisations that represent the public, particularly Aboriginal and Torres Strait Islander peoples and vulnerable members of the community. Groups will include the Ahpra Consumer Advisory Council, the Consumer Health Forum, the Ahpra Aboriginal and Torres Strait Islander Health Strategy Group, Consumers' Federation of Australia, the Australian Indigenous Doctors' Association (AIDA), Health Consumers of Rural and Remote Australia Inc, Australian Council of Social Service and the Australian Consumers' Association (CHOICE).

The Board will take the feedback from patients and consumers, particularly vulnerable members of the community into consideration.

## **3. What might be the unintended impacts for patients and consumers particularly vulnerable members of the community? How will these be addressed?**

The Board has carefully considered any unintended impacts of the proposal to introduce health checks for late career doctors. The Board has not identified any specific unintended impacts, however consulting with relevant organisations and vulnerable members of the community will help the Board to identify any other potential impacts.

There may be an impact in a small number of communities if a late career doctor was the only doctor providing health care in a community and had to change how they practise because of health issues affecting their capacity to provide safe care. However, the Board considers the provision of safe care, particularly to vulnerable community members is paramount.

The Board will fully consider and take actions to address any potential negative impacts for patients and consumers that may be raised during consultation particularly for vulnerable members of the community.

## **4. How will this proposal impact on Aboriginal and Torres Strait Islander Peoples? How will the impact be different for Aboriginal and Torres Strait Islander Peoples compared to non-Aboriginal and Torres Strait Islander Peoples?**

The Board has carefully considered any potential impact of the proposal to introduce health checks for late career doctors on Aboriginal and Torres Strait Islander Peoples and how the impact might be different to non-Aboriginal and Torres Strait Islander Peoples in order to put forward the proposed option for feedback as outlined in the consultation paper.

The Board has weighed the potential small impact on Aboriginal and Torres Strait Islander Peoples if a late career doctor in their community has to change how they practise because of health issues identified during the health check, with the clear benefits to the community and individual patients of ensuring late career doctors are able to continue to provide safe care to their patients.

There are 0.4% of doctors in Australia who identify as Aboriginal and/or Torres Strait Islander. This is around 500 practitioners. A very small number are aged 70 years or older, with almost 80 percent aged under 50 years of age. The proposal is therefore not likely to have a significant impact on doctors who identify as Aboriginal and/or Torres Strait Islander.

The Board's engagement through consultation will help to identify any other potential impacts and meet our responsibilities to protect safety and health care quality for Aboriginal and Torres Strait Islander Peoples.

#### **5. How will consultation about this proposal engage with Aboriginal and Torres Strait Islander Peoples?**

The Board is committed to the National Scheme's [Aboriginal and Torres Strait Islander Cultural Health and Safety Strategy 2020-2025](#) which focuses on achieving patient safety for Aboriginal and Torres Strait Islander Peoples as the norm, and the inextricably linked elements of clinical and cultural safety.

As part of the consultation process, the Aboriginal and Torres Strait Islander Health Strategy Group is being consulted. The Board will meaningfully engage with Aboriginal and Torres Strait Islander Peoples, including continuing to engage with Aboriginal and Torres Strait Islander organisations and stakeholders. The Board will also seek feedback from the Australian Indigenous Doctors' Association (AIDA).

#### **6. What might be the unintended impacts for Aboriginal and Torres Strait Islander Peoples? How will these be addressed?**

The Board has carefully considered what might be any unintended impacts for introducing health checks for late career doctors. There is a clear benefit to Aboriginal and Torres Strait Islander Peoples and individual patients of the Board ensuring late career doctors are able to provide safe care to their patients.

Continuing to engage with relevant organisations and Aboriginal and Torres Strait Islander Peoples will help us to identify any other potential impacts. We will consider and take actions to address any other potential negative impacts for Aboriginal and Torres Strait Islander Peoples that may be raised during consultation.

#### **7. How will the impact of this proposal be actively monitored and evaluated?**

Part of the Board's work in keeping the public safe is ensuring that all the Board's standards, codes and guidelines are regularly reviewed.

In developing the proposal to introduce health checks for late career doctors, and in keeping with this, if the proposal is implemented, the Board will regularly review the *Health checks for late career doctors registration standard* to check it is working as intended.

## Option 3

### Registration standard:

Health checks for late careers doctors

Effective date: TBC

## Summary

Medical practitioners who are aged 70 years of age and older and engaged in any form of practice are required to undergo a general health check to support them to get any care they need and so they can continue to practise safely throughout their working lives.

This registration standard sets out the details of the Medical Board of Australia's (the Board) required health checks for medical practitioners aged 70 years and older.

## Does this standard apply to me?

This standard applies to all registered medical practitioners who are aged 70 years and older, except those with non-practising registration.

## What must I do?

To meet this registration standard, you must:

- undergo a general health check that is conducted:
  - every three years for medical practitioners aged 70 to 79 years, when you turn 70, 73, 76 or 79 during the registration period (1 October to 30 September)
  - every year for medical practitioners aged 80 years and older.

The Board will issue guidance on the contents of the health check.

## Are there exemptions to this standard?

Registered medical practitioners aged 70 years of age and older who have non-practising registration are exempt from the requirements of this standard.

## What does this mean for me?

### When you apply for registration

If you are a medical practitioner aged 70 years and older and you are applying for registration as medical practitioner in Australia<sup>106</sup>, you will need to:

- declare whether you have completed the general health check described in this registration standard within the past 12 months
- make a declaration on the application indicating whether you have an impairment that detrimentally affects, or is likely to detrimentally affect, your capacity to practise the profession and providing information when relevant.

### When you renew your registration

If you are aged 70 or older, when you apply to renew your registration each year you will need to declare whether you have complied with this standard. This involves:

- confirming that you have completed the required general health check as required in this standard

<sup>106</sup> For example, you could be registering for the first time or be applying for registration after being unregistered or holding non-practising registration.

- completing the annual statement declaring whether or not you have an impairment that detrimentally affects, or is likely to detrimentally affect, your capacity to practise the profession. (When relevant you will need to provide additional information.)

### During the registration period

Your compliance with this standard may be audited from time to time.

### Evidence

You need to retain for three years the confirmation of your health check provided to you by your medical practitioner when you have your health check. This document confirms that you have completed a health check within the relevant timeframes.

## What happens if I don't meet this standard?

The possible consequences of not meeting this standard are set out in the National Law, including that:

- the Board can impose a condition or conditions on your registration or can refuse your application for registration or renewal of registration, if you don't meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)
- a failure to undertake the health check required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the Board (section 128 of the National Law), and
- registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for health professionals (section 41 of the National Law).

### More information

The health check must be conducted in accordance with guidance issued by the Board from time to time.

### Transition

During the first year of the operation of this standard, health checks will occur for doctors at the age of 70 or 71 years; 73 or 74 years; 76 or 77 years; and all doctors aged 79 years and older.

### Authority

This registration standard was approved by the Ministerial Council for the National Registration and Accreditation Scheme (the National Scheme) on XXXX.

Registration standards are developed under section 38 of the National Law and are subject to wide-ranging consultation.

### Definitions

**Impairment** means a physical or mental impairment, disability, condition, or disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, your capacity to practice the profession. Section 109 of the National Law requires you to declare any impairments at the time of application for registration and renewal. If you have an impairment, you will need to provide details of the impairment and how it is managed.

**Late career doctors** are medical practitioners aged 70 years of age and older.

**National Law** means the Health Practitioner Regulation National Law, as in force in each state and territory.

**Practice** means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

## Review

This registration standard will be reviewed from time to time as required. This will generally be at least every five years.

### Questions for consideration

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?
  - 7.2. Is there anything missing that needs to be added to the draft registration standard?
  - 7.3. Do you have any other comments on the draft registration standard?



## Appendix C:

# Draft documents and resources required for the health check model

### Documentation to support health checks

The following documents and resources are provided as examples of information that may be useful for the late career doctor, the assessing/treating doctors and other health practitioners who may be conducting the health checks. The Board is including these documents to:

- provide clarity and detail about what would be involved in the proposed health check
- seek feedback on the additional resources to ensure they are clear and useful.

If the Board proceeds with the proposed approach, these resources will be made widely available. There may also be potential for the questionnaire and examination guide to be incorporated into practice-based software to facilitate the completion of the health check.

The Board will also develop frequently asked questions for late career doctors and their assessing/treating doctors which will be published to support the implementation of the health checks.

[C-1 Pre-consultation questionnaire](#)

[C-2 Health check examination guide](#)

[C-3 Cognitive function in late career doctors: guidance for screening](#)

[C-4 Health check confirmation certificate](#)

[C-5 Stages of the health check flowchart](#)

### Additional resources

In addition to the supporting documentation, links to resources and information could include:

1. RACGP [Guidelines for preventive activities in general practice](#) (the Red Book)
2. educational resources that could be delivered through groups such as the Primary Health Networks, Doctors' Health Advisory Services or specialist medical colleges
3. [Choosing Wisely Australia](#): Resources including tests, treatments, and procedures for healthcare providers and questions and advice for consumers
4. additional evidence-based practice guidance for ongoing treatment and referrals
5. information about transitions in practice
6. Doctors' health services
7. providers of professional indemnity insurance (medical defence organisations)
8. professional organisations such as specialist medical colleges, medical associations, and the Australian Medical Association (AMA).

## Questions for consideration

8. The Board has proposed supporting documents and resources to support option 3. The materials are:
- C-1. Pre-consultation questionnaire that late career doctors would complete before their health check
  - C-2. Health check examination guide that the assessing/treating doctors would use 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 (Attachments C-1 to C-5) clear and relevant?
- 8.2 What changes would improve them?
- 8.3 Is the information required in the medical history (C-1) appropriate?
- 8.4 Are the proposed examinations and tools listed in the examination guide (C-2) appropriate?
- 8.5 Are there other resources needed to support the health checks?

Note: this form is indicative of what the Board proposes the questionnaire will contain. Sufficient space for answers will be provided in the final version.

## Pre-consultation questionnaire

### Confidential medical history

To meet the requirements of the Medical Board of Australia's *Registration standard: Health checks for late career doctors*, all registered medical practitioners aged 70 years and older must undergo a general health check at least every three years (and annually for doctors aged 80 years and older).

The Medical Board will NOT see the results of the health check which is confidential between the late career doctor and their assessing/treating doctor. The Board will ask late career doctors to confirm they have had the general health check, when they apply to renew their medical registration each year.

Further information about the health checks can be found on the Board's website [www.medicalboard.gov.au](http://www.medicalboard.gov.au).

### Instructions

This questionnaire should take about 10 minutes to complete. Please take it with you to your appointment to discuss confidentially with your assessing/treating doctor. It is anticipated the health check will take between 40 and 60 minutes.

*This medical history and the completed examination is **NOT** to be sent to Ahpra. It remains the property of the late career doctor and their assessing/treating doctor/s.*

### Personal details

Full name:

---

Date of birth:

---

Gender:

---

Country of birth:

---

Languages spoken other than English:

---

Do you identify as Aboriginal and/or Torres Strait Islander?

---

### Contact details

Residential address:

---

Phone (business hours):

---

Mobile:

---

Email:

---

## Health support

Current GP (Name and contact details):

---

Other GP:

---

Other specialists (if seeing any):

---

Other health practitioners (if seeing any):

---

When was your most recent comprehensive health check?

---

## Current professional practice

*In the past 12 months, which best describes your professional practice?*

Type of practice/specialty:

---

Do you do procedural work?

---

Have you made any changes to your scope of practice?

---

How many hours do you work per week (on average)?

---

Do you work:                      Required on-call                      After-hours

---

Region of practice:              Metropolitan                      Regional                      Rural                      Remote

---

Practice arrangements:      Group                      Solo                      Health service

---

Support staff:                      Practice manager                      Nurse                      Other

---

Are you involved in:              Regular formal peer interactions                      Informal peer interactions

---

Other types of employment, including non-medical work:

---

## Social history

Who lives in your household?

---

Do you have caring responsibilities for a family member or friend?

---

Who do you care for and what are your responsibilities?

---

Are you satisfied with your social engagement?

---

## Past history

Do you have a significant health condition that has caused you to be away from work for more than two weeks in the last 12 months:

Medical condition  Yes  No

Surgical condition  Yes  No

Dental condition  Yes  No

Mental health condition  Yes  No

Provide details

## Family history

Do you have a significant family history of ...

Diabetes  Yes  No

Cardiovascular  Yes  No

Thyroid  Yes  No

Cancer  Yes  No

Mental illness and/or disorders such as anxiety  Yes  No

Dementia  Yes  No

Other neurological (including strokes)  Yes  No

Other  Yes  No

Provide more details

## Medications, allergies and vaccinations

Do you have any allergies or sensitivities?  Yes  No

Provide details:

Are you currently vaccinated / immunised against: (tick all that apply)

<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Tetanus
<input type="checkbox"/>	Hep A	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Typhoid
<input type="checkbox"/>	Hep B	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	TB	<input type="checkbox"/>	Whooping cough
<input type="checkbox"/>	H Zoster	<input type="checkbox"/>	Pneumococcal	<input type="checkbox"/>	COVID-19		

Other:

Describe your usage of the following over the past 12 months:

Prescription medications:

---

Over the counter medications:

---

Herbal supplements, vitamins or minerals:

---

## Current health issues

What are your current health issues?

---

Have you had the following investigations in the last 12 months? (tick all that apply)

<input type="checkbox"/>	FBE	<input type="checkbox"/>	Faecal occult blood test
<input type="checkbox"/>	U&E / Creatinine	<input type="checkbox"/>	Cervical screening
<input type="checkbox"/>	LFT	<input type="checkbox"/>	Prostate assessment
<input type="checkbox"/>	Lipids	<input type="checkbox"/>	Mammogram
<input type="checkbox"/>	BSL/ Glucose OR HbA1c	<input type="checkbox"/>	Radiology (e.g. BMD)
<input type="checkbox"/>	Vitamin B12	<input type="checkbox"/>	Visual check
<input type="checkbox"/>	Thyroid function tests	<input type="checkbox"/>	Audiology check
<input type="checkbox"/>	Vitamin D	<input type="checkbox"/>	Dental check
<input type="checkbox"/>	ECG	<input type="checkbox"/>	Skin check

Comments (were there abnormalities?):

---

## Alcohol and substance review

Do you have alcohol free days?  Yes  No

---

How often do you have a drink containing alcohol?

---

How many standard drinks do you have on a typical day when you are drinking?

---

How often do you have six or more standard drinks on one occasion?

---

Do you use sedatives, benzodiazepines, opioids or medicinal cannabis at all?  Yes  No

If yes, how often and how much?

---

Do you use any recreational or illicit drugs?  Yes  No

If yes, how often and how much?

---

Do you use tobacco?  Yes  No

If yes, how often and how much?

---

Comments:

---

---

\*Refer to AUDIT assessment for further information at <https://auditscreen.org/>

## Lifestyle

Do you ...

Undertake 150 minutes of moderate level exercise per week?  Yes  No

---

Use aids for hearing, vision, walking?  Yes  No

---

Regard your current diet as healthy?  Yes  No

---

Comments:

---

## Sleep

In the last 12 months ...

Have you had problems initiating or maintaining sleep?  Yes  No

---

When you sleep, do you snore persistently or stop breathing?  Yes  No

---

Do you wake up refreshed?  Yes  No

---

Has your partner observed disturbed sleep behaviour?  Yes  No  
 N/A

---

Comments:

---

## Cardiovascular

In the last 12 months have you experienced ...

chest pain  Yes  No

---

palpitations  Yes  No

---

breathlessness  Yes  No

---

dizziness on standing  Yes  No

---

Comments:

---

---

## Respiratory

*In the last 12 months have you experienced ...*

voice change  Yes  No

sputum  Yes  No

shortness of breath  Yes  No

cough  Yes  No

haemoptysis  Yes  No

Comments:

---

## Gastro-intestinal

*In the last 12 months have you experienced ...*

problems with oral or dental health  Yes  No

loss of weight  Yes  No

changed bowel habits  Yes  No

faecal incontinence  Yes  No

abdominal pain or lumps  Yes  No

nausea or vomiting  Yes  No

loss of blood per rectum  Yes  No

Comments:

---

## Genito-urinary

*In the last 12 months have you experienced ...*

urinary incontinence  Yes  No

haematuria  Yes  No

urinary frequency  Yes  No

nocturia  Yes  No

urgency  Yes  No

Comments:

---



---

## Neurological

*In the last 12 months have you experienced ...*

headaches  Yes  No

any falls or unsteadiness  Yes  No

speech or language changes  Yes  No

fits, faints, funny turns  Yes  No

sensory changes or loss particularly in hands / feet  Yes  No

tremors or clumsiness  Yes  No

Comments:

---

## Mental health

*In the last 12 months have you ...*

felt down, depressed or hopeless?  Yes  No

felt little interest or pleasure in doing things?  Yes  No

been feeling particularly nervous or anxious?  Yes  No

Comments:

---

## Cognitive function

*In the last 12 months have you had ...*

difficulties with complex decision making  Yes  No

problems with calculations e.g. determining drug doses  Yes  No

problems with learning new information  Yes  No

difficulties with concentration e.g. while reading  Yes  No

problems with recall (including names, side effects or indications of drugs)  Yes  No

deterioration in serial cognitive testing (if done)  Yes  No

any cognitive testing  Yes  No

Comments:

---

## Musculo-skeletal

*In the last 12 months have you experienced ...*

joint pain / joint deformity  Yes  No

restriction of back and neck movement  Yes  No

---

---

restricted movement in upper limb joints  Yes  No

---

back and neck pain  Yes  No

---

restriction of other joints  Yes  No

---

Comments:

---

### Manual dexterity

*In the last 12 months have you experienced any change in...*

---

the ability to type / write  Yes  No

---

ability to undertake usual procedures / tasks at work  Yes  No

---

dexterity of either hand  Yes  No

---

Comments:

---

### Skin and haematology

*In the last 12 months...*

---

do you consider you have had enough exposure to sunlight for Vitamin D sufficiency?  Yes  No

---

have you had spontaneous bruising or bleeding?  Yes  No

---

have you noticed lumps / bumps / enlarged nodes?  Yes  No

---

had a skin check?  Yes  No

---

Comments:

---

### Hearing

*In the last 12 months have you experienced ...*

---

difficulty with hearing in your work environment  Yes  No

---

difficulty hearing in crowds  Yes  No

---

difficulty with hearing one on one in a quiet room  Yes  No

---

tinnitus  Yes  No

---

Comments:

---

---

## Endocrinology

*In the last 12 months have you experienced ...*

diabetes  Yes  No

a thyroid disorder  Yes  No

other  Yes  No

Comments:

---

## Sight

*In the last 12 months have you experienced ...*

blurred or distorted vision, despite spectacles  Yes  No

problems driving at night or in a low contrast environment  Yes  No

diplopia / double vision  Yes  No

inability to read print e.g. on small ampoules or in crosswords  Yes  No

Comments:

---

## Confirmation of questionnaire details

I declare that all the answers provided on this form and information provided to my assessing/treating doctor during this health check, is to the best of my knowledge, true and correct.

**Signed:**

**Date:**

---

### Do not send this form to the Medical Board of Australia or Ahpra

When you renew your medical registration each year, the Medical Board of Australia (the Board) will ask you to declare that a health check has been completed in the last three years if you are 70 or over and annually from the age of 80 years.

Further information about the health checks can be found on the Board's website: [www.medicalboard.gov.au](http://www.medicalboard.gov.au)

## Health check examination guide

The assessing/treating doctor should use their clinical judgement to determine which examinations and investigations are required for each late career doctor.

### Patient details

Full name:

---

Date of birth:

---

Date of consultation:

---

### General

Height:

---

Weight:

---

BMI:

---

HR and rhythm:

---

BP standing:

---

BP sitting:

---

Appearance:

---

## Examinations

### Cardiovascular

Cardiac murmurs:

---

Carotid bruits:

---

Abdominal bruits:

---

Peripheral pulses:

---

Peripheral oedema:

---

### Respiratory

Air entry:

---

Added sounds:

---

### Gastro-intestinal

Abdominal palpation including masses and organomegaly:

---

## Genito-urinary

Urine analysis:

---

Genital examination and follow-up as indicated:

---

## Mental health

Psychomotor changes:

---

Affect and mood:

---

Thought form and content:

---

## Neurological

Tremor:

---

Romberg's test:

---

Extra-ocular movements:

---

Finger nose test:

---

Reflexes:

---

Sensation and light touch loss:

---

Gait, heel/toe:

---

Palmomental reflex:

---

Strength:

---

## Musculo-skeletal

Rising from chair / sit to stand:

---

Range of motion of upper limbs / lower limbs:

---

Range of motion of back:

---

Joint abnormalities:

---

## Skin and haematology

Lumps and lymph nodes:

---

Bruising:

---

Petechiae:

---

Skin lesions / integrity:

---

## Hearing

Review of audiological assessment, if available:

---

Otoscopic examination:

---

Finger rub test (and identify side):

---

Computerised hearing tests:

---

## Sight

Review of visual testing report, if available:

---

Visual acuity: Snellen chart, Amsler grid:

---

Confrontation fields:

---

## Manual dexterity

'Play' piano:

---

## Cognitive function

Refer to resource statement about cognitive screening assessment on the Board's website [\(C-3\)](#)

---

A: One of the following preferred comprehensive screening assessment tools for Mild Cognitive Impairment:

A.1 Montreal Cognitive Assessment (MoCA):

A.2 Addenbrooke's Cognitive Examination (ACE-III):

---

B: Both of the following available non-comprehensive screening assessment tools with lower sensitivity and specificity for Mild Cognitive Impairment:

B.1 Standardised Mini-Mental State Examination (SMMSE):

B.2 Clock Drawing test (CDT):

---

Further tests available at [www.dementiaresearch.org.au/doms](http://www.dementiaresearch.org.au/doms)

Reference: Clinical Examination: A Guide to Physical Diagnosis. Talley N.J. and O'Connor S. 8<sup>th</sup> Edition. 2017. Elsevier Health Publishers

## **Guidance:**

# Screening cognitive function in late career doctors

Draft: May 2024

## Cognitive function in late career doctors

Overall cognitive function tends to decline with age, although this is not uniform.<sup>1</sup>

Fluid intelligence - the capacity to think flexibly, apply analytical reasoning and process information quickly (that is, executive function) - declines with age. In contrast, crystallised intelligence, a measure of accumulated knowledge and wisdom that is dependent on education and experience, remains stable or improves with age.

In a US study of doctors across the career cycle and specialties, average scores on most domains of cognitive function declined by the age of 75.<sup>2</sup> The cognitive domains with the most significant decline were attention, memory and reasoning. However, the study also indicated there was greater inter-individual variation in cognitive function in the oldest doctors.

In a separate study of cognitive function in surgeons, approximately 80% of practising surgeons aged 60 to 64 and 40% of surgeons aged 70 years and older performed within the range of younger surgeons.<sup>3</sup> This heterogeneity emphasises that cognitive decline in older doctors is not inevitable.

Some older doctors may experience Mild Cognitive Impairment (MCI). MCI is the interval between optimal cognitive function and clinical dementia.<sup>4</sup> It is possible that some older doctors do have unrecognised MCI which is a more likely finding than dementia. Doctors have a theoretically lower risk of dementia because of their level of education and occupational complexity.

The overall prevalence of MCI amongst practising doctors is not known. However, 54% of an older cohort of doctors in the NSW Impaired Registrants Program were diagnosed with cognitive impairment.<sup>5</sup>

The cumulative incidence of dementia in people with MCI who have been followed up for two years is 15%.<sup>4</sup> This suggests a large proportion of people with MCI have cognitive decline due to non-neurodegenerative causes (see reversible causes below).

## Screening of cognitive function

### Principles of cognitive screening

We note the following guiding principles:

1. most importantly, the screening assessment of cognitive function may be threatening to a doctor and should be approached sensitively
2. diagnosis of cognitive impairment is a multi-step process that includes, but is not limited to, a corroborative history from an informant, appropriate investigations and specialist review
3. an initial screening assessment of cognitive function is essential to provide either a trigger for further evaluation, or a baseline for future comparison and surveillance
4. while the cognitive screening may indicate the need for further evaluation, a full cognitive evaluation is outside the scope of the health check. If the initial cognitive screening indicates concern, a follow-up visit and/or referral to an appropriate specialist (geriatrician, old age psychiatrist, neurologist) will be required
5. after the cognitive function screening, counselling about potentially modifiable risk factors is recommended for all doctors, especially those at greater risk.



## Screening of cognitive function

Please refer to the cognitive function section of the accompanying Medical History ([C-1](#)).

Signs of cognitive impairment that may be observed during the screening include:

- difficulty providing a coherent history
- changes in speech (such as word finding difficulties, dysphasia, dysarthria)
- mood changes (such as emotional lability).

Other neurological signs, such as abnormal gait, are also relevant.

## Cognitive screening tools

There are numerous brief instruments available to do a screening of cognitive function in general practice. Many of these tests are unsuitable for highly educated individuals and for detecting MCI. As noted earlier, the results of such tests, in isolation, are not necessarily diagnostic.

The following two comprehensive screening tools measure executive function and have very good sensitivity in detecting MCI (90%).<sup>6</sup>

1. The *Montreal Cognitive Assessment* (MoCA) takes 5 - 10 minutes to administer. Users must register and complete a one-hour training session, at a cost, to administer the MoCA. Recertification is required every two years ([www.mocatest.org](http://www.mocatest.org)).
2. The *Addenbrooke's Cognitive Examination* (ACE-III) takes 15 - 20 minutes to administer. No formal training or fee is required to complete the ACE-III which can be downloaded easily, along with complete instructions for scoring (<https://sydney.edu.au/brain-mind/resources-for-clinicians/dementia-test.html>).

A previous version of the ACE-III was used in a UK study of medical and dental practitioners referred for performance assessment.<sup>7</sup>

The following two non-comprehensive screening tools are also available. Although commonly used in general practice, they were designed to detect dementia. Both have low sensitivity (< 50%) and specificity in detecting Mild Cognitive Impairment relative to healthy controls.<sup>6</sup>

3. The *Mini Mental State Examination* (MMSE) does not examine for executive function, the importance of which was discussed earlier. (The copyright for use of the MMSE is held by Psychological Assessment Resources, Inc: [www.parinc.com](http://www.parinc.com)).

The limitations of the MMSE were demonstrated by the finding that the mean score in a group of impaired older doctors considered to have cognitive impairment after neuropsychological assessment was 28/30.<sup>5</sup>

A study of older people with greater education showed a MMSE score of less than 28 was more sensitive in detecting impairment than the standard threshold of 23 or less.<sup>8</sup>

4. The *Clock Drawing Test* (CDT) may have limited utility in the assessment of executive function. There are multiple scoring systems. The five-point scoring method should be used where the doctor is asked to:
  - a. draw a clock (1 point for circle) and insert all the numbers (1 point). There should be even spaces between numbers, and 12, 3, 6, and 9 in their correct places (1 point)
  - b. then to add clock hands pointing to 'ten past eleven' (2 points).

Using both the MMSE and CDT may improve sensitivity in detecting some cases of MCI, but their overall limitations remain.

In addition, there are online tests of cognitive function that are available, such as the Cog-State which requires registration. It should be noted that there is no reliable online test with adequate sensitivity/specificity for detecting cognitive impairment in a group of high functioning individuals.

### Further evaluation

Potentially reversible causes of cognitive impairment include:

- depression, anxiety or another mental disorder
- substance abuse
- polypharmacy especially certain medications, like anti-cholinergic drugs and benzodiazepines
- physical comorbidities, like obstructive sleep apnoea.

Standard pathology tests to determine a reversible cause for cognitive impairment includes FBC, EUC, LFTs, calcium, folate, vitamin B12 and TFTs.<sup>9</sup> Routine syphilis and HIV serology and EEG are not usually indicated.

Neuroimaging may be requested by the assessing/treating doctor or a specialist medical practitioner if deemed appropriate after the results of cognitive screening. Structural imaging, such as a cerebral CT scan, may be considered although cerebral MRI scan is more sensitive. It may be reasonable to defer any neuroimaging to an appropriate specialist.

Some late career doctors may request or, based on the outcomes of their cognitive screening, require more comprehensive cognitive evaluation. In such cases, an appropriate specialist should determine whether neuropsychological assessment is required.

### General advice about brain health lifestyle changes

It is appropriate to provide general advice about brain health lifestyle changes that may delay the onset or progression of cognitive impairment. There is evidence to recommend regular physical exercise and cognitive training.<sup>4</sup>

Individual factors that have been shown to reduce the risk of cognitive impairment<sup>10</sup> can be identified for formal management, however use of a formal aggregate or risk score is not recommended.

The following factors have been shown to reduce the risk of cognitive impairment:

- low/moderate alcohol intake
- a healthy/Mediterranean diet
- high cognitive activity
- regular physical exercise
- cognitive training.<sup>4</sup>

The following factors have been shown to increase the risk of cognitive impairment:

- coronary heart disease
- physical inactivity
- chronic kidney disease
- diabetes mellitus
- raised cholesterol
- smoking
- midlife obesity
- midlife hypertension
- depression.

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Letterhead of treating health practitioner

C-4

## Health check confirmation certificate

This is to certify that

Name

Date of birth

has completed a health check on

DATE

as required under the Medical Board of Australia's *Registration standard: Health checks for late career doctors*.

I have reviewed the medical history and completed the examination as required.

Signed

Name

Date

Practice

Practice address

Phone/email

Provider number

This statement should be provided to the late career doctor who has completed the health check. The late career doctor should retain the certificate for audit purposes as required.

The clinical information relating to the health check should remain confidential between the late career doctor and their assessing/treating doctor/other health practitioner/s involved in the health check.

## Stages of the health check

