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RACP submission to the MBA: Health checks for late career doctors

September 2024

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 22,200 physicians and 9,800 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Foreword

We thank the Medical Board of Australia (MBA) for the opportunity to comment on the *Health checks for late career doctors Consultation Regulation Impact Statement*. This is an important consultation for the RACP, its members and their patient communities. RACP members approaching or aged 70 years or above comprise a significant number of our membership.

This submission draws on existing College work and perspectives of individual members, the RACP Member Health and Wellbeing Committee, and integrating additional feedback from the Australia New Zealand Society of Palliative Medicine (ANZSPM), Endocrine Society of Australia (ESA), Australian and New Zealand Society for Geriatric Medicine (ANZSGM), and the Australian and New Zealand Bone and Mineral Society (ANZSBM). We thank these RACP bodies and specialty societies for their contribution.

We encourage the MBA to engage further with the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) as the RACP body whose members offer specific expertise on the proposed regulatory options.

Workforce considerations

The RACP favours initiatives to uphold, promote and enhance patient safety as a paramount concern in our health system. Assuring collective public safety requires the MBA to also consider broader workforce issues, including potential additional pressures on the already overburdened medical workforce that could result from any overly 'blunt' regulatory approach, particularly for both workforce distribution of and access to medical care.

Physician specialties with an older age distribution

The MBA should consider the potential for inequitable regulatory burden and adverse consequences for RACP specialties with a comparatively older age distribution, including public health physicians, sexual health physicians, addiction medicine physicians, and occupational and environmental physicians (the last-mentioned being a key sub-specialty that the Board requires for one of the proposed regulatory options).

Some RACP specialties stand to be disproportionately impacted by the reforms in the short term. It is essential to continue to support the important services these specialties provide, including to oversight of physician trainees, Junior Medical Officers and others within the health system.

In addition, it is imperative to look at a broader range of ways to support later career doctors, including for them to continue working safely and productively and, when appropriate, support transitions around scope of practice and towards retirement. This would involve tools for career planning, including professional and personal supports.

Physician disciplines on the Skilled Occupation List

A range of specialties are in shortage, being on the Home Affairs Skilled Occupation List to attract skilled migrants possessing the necessary competencies.[1] [2]

[1] Australian Government Department of Home Affairs Skilled Occupation List [online]; Skilled occupation list (homeaffairs.gov.au)
[2] Australian Bureau of Statistics, Australian and New Zealand Standard Classification of Occupations, 2013, Version 1.2 UNIT GROUP 2533 SPECIALIST PHYSICIANS [online]; 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, 2013, Version 1.2 (abs.gov.au)

The regulatory impact statement does not consider the medical testing skilled migrants now undergo as a condition of entry to Australia for residence and work. The RACP assumes the proposed health checks would apply in addition to existing medical testing for all skilled migrants[3], rather than as a single assessment. This is a point the MBA should clarify this in consultation and also consider potential disincentives for older physicians considering Australia as a working destination.

Rural/remote healthcare impacts

AIHW data indicates that specialist shortages are a significant issue in rural and remote areas and workforce distribution between rural and metropolitan areas is far from uniform, with the supply of specialists decreasing with increasing remoteness.[4] The ABS 2023 patient experience survey found that 27.9% of the large sample of respondents waited longer than they felt acceptable to get an appointment with a medical specialist.[5]

The MBA must try to ensure the regulation does not encourage unnecessary retirement of older specialists from the workforce in rural, regional and remote areas given that late-career specialists fill critical gaps in these under-served regions.

The loss of even a small number of specialists could significantly reduce healthcare access in rural, regional and remote areas, worsening the already unequal distribution and leading to higher workload and burnout for rural doctors overall.

Workforce burnout

An RACP member survey from 2022 identified that burnout is a persistent problem amongst physicians, with 87% reporting concern about staff burnout, and 81% drawing an association between workforce burnout and patient delays in screening leading to exacerbations of medical conditions.[6]

With escalating healthcare needs, pressure in our hospitals with resourcing limitations, burnout and any unwarranted additional stress of regulatory requirements must be considered. Existing regulatory requirements require careful consideration, such as health declarations at annual renewal of registration, Continuing Professional Development (CPD) such as peer review activities and demonstrating Recency of Practice, require consideration to avoid duplication and additional undue complexity. We encourage the MBA to consider how its existing checks for registrants can be used to reassure ongoing fitness for practice.

Interface with the National Medical Workforce Strategy

We encourage the MBA to engage with the Department of Health and Aged Care (DoHAC) to consider the interaction of its proposals with the priorities in the National Medical Workforce Strategy (2021-2031).[7] This is particularly in relation to identified priorities of Improve Medical Workforce Distribution, Enhance Workforce Capacity, Address Workforce Maldistribution and Shortages, Strengthen Workforce Flexibility and Resilience, Promote Medical Training and Education Alignment, Support Innovation and Future Healthcare Needs, and Promote Equity

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[3] Australian Government Department of Home Affairs [online]; What health examinations you need (homeaffairs.gov.au)
[4] Australian Institute of Health and Welfare – Rural and Remote Health
[5] Australian Bureau of Statistics, Patient Experiences 2022-23 Financial Year [online]; Patient Experiences, 2022-23 financial year | Australian Bureau of Statistics (abs.gov.au)
[6] RACP Media Release: Calls for Federal Government to release workforce modelling and boost resources as survey shows major burnout among doctors [online]; Calls for Federal Government to release workforce modelling and boost resources as survey shows major burnout among doctors media release (racp.edu.au)
[7] Department of Health and Aged Care, National Medical Workforce Strategy 2021-2031 [online]; National Medical Workforce Strategy 2021–2031 | Australian Government Department of Health and Aged Care

and Diversity in the Workforce.

Consultation responses

While the RACP supports the principle of proactive approaches to monitor health related practice risks for late career doctors (except those with non-practising registration), the Board preferred option would require doctors from the age of 70 years to undergo general health checks with their GP or another doctor every three years, and yearly from 80 years of age. There are a range of RACP member concerns with this model.

Whether a health check should apply to all 'later-career' medical practitioners with practicing registration (questions 1-2)

There are some member concerns that the 70-year threshold will be used as a blunt tool to define 'late career' and imply heightened 'practice risk'. How effective this testing age would be to truly mitigate practice risk is open to debate.

Some members and specialty societies expressed support for all doctors over 70 to undertake a health check every three years and every year from 80 years of age.

Other members indicated that 70 years appeared to be an arbitrary minimum age and questioned why this specific age had been selected, noting anecdotally that doctors of this age tend to be significantly experienced, offer valuable supervision, training and support to younger doctors in clinically complex scenarios. Members also noted that declines in competency and health can occur at point in the life stage, driven by physiology, lifestyle or environmental factors. They expressed the importance of all doctors remaining in good health for the safety of their patients, irrespective of age.

Two key considerations the RACP urges the Board to keep in mind are:

- ***The conditions for practice in each RACP specialty differ***: including theoretical, practical and differential diagnostic skills, scopes, and physiological competencies across proceduralists, general specialists, sub-specialists and research focused disciplines. There was a strong view amongst members that there should be clear definitions of requirements for competent practice in each specialty, and that these various requirements may need to be reflected in a regulatory system that accommodates 'shades of grey' in age cut-offs or applicable life stages

- ***The ageing brain and medical practice***: research collated by an RACP member identifies that doctors over 65 and under the age of 80 can achieve the same clinical quality as younger peers, with some additional time allowance for complex tasks; that doctors can continue to learn new tasks up until roughly the age of 80; and that compared to doctors under the age of 65, those over the age of 65 had built experiential learning into their practice that minimised risk.[8] This would suggest there is some fluidity in when the checks could commence, with advanced age being a more important marker for mandatory purposes. One option proposed by an RACP specialty society is that medical practitioners over 80 be assessed by a Geriatrician with expertise in older age cognitive impairment.

[8] RACP rehabilitation physician and national disability expert member submission, details available on request and with member permission

Where the minimum age for retirement in general is now 67 and there is a no guarantee it will not be extended further in future, any checks must be aligned with the expected extended longevity of working life across all professional career groups.

Non-specificity of general health checks and cognitive screening (questions 3-4)

The predominant view of RACP specialty societies is that any tests should be specific to scope of practice, including specific competencies and capabilities. The testing arrangements the Board proposes in its draft standard are too general and do not necessarily bear upon the ability of a medical professional to perform their role.

The Board's proposed check is broadly consistent with the MBS rebated health assessment that is available to all older Australians voluntarily and should not be duplicated for regulatory purposes.

Differing mental, social and interactive capabilities are involved across various fields of medical practice.[9] General cognitive function tests could be costly and miss specificity particular to scope. Specific tests of executive function, the core cognitive domain relevant in a direct assessment of cognitive function in medicine, may be more appropriate than general cognitive assessments.

Many Australians have chronic health issues of the sort noted in the draft standard and general health check tool. The AIHW indicates that 61% of Australians or 15.4 million people, including a significant minority of younger people, have chronic health conditions.[10] Where these do not impact employment performance for an individual worker, the conditions are deemed personal health information that does not require disclosure.

What is more useful is a testing arrangement that is uniquely designed and tailored to unique scopes of medical practice with abundant supporting resources and tailored protocol-based guidelines and assistance. Using one example given by a specialist society: proceduralist assessment requires dexterity testing; neck and upper limb assessment, but this is not so important for other specialities with a greater focus on sedentary communication skills (for example, palliative care).

Tailored approaches would be relevant to what a physician does professionally, and their unique and individual daily interface with patients, ensuring an impartial and fair assessment process based on scope specific tools and guidance. Assessing practitioners must be clear on their defined responsibilities. It is an unreasonable expectation that all GPs possess comprehensive and specific knowledge of the competencies involved in specialist scopes of practice and related protocol based impartial assessment tools. This would naturally limit the usefulness of Option 3 in its present form. The RACP and specialty societies are well positioned to support the MBA in developing, refining and advising on such tools in our expert capacities.

Furthermore, while GP colleagues could undertake specific testing with specific scope related training, resourcing and support, some members have expressed concerns about unnecessary complexities posed for the relationship a specialist has with their treating GP in taking a GP led approach, particularly for rural, regional and remote areas. For example:

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[9] Elena Zelesniak et al, 'Defining competence profiles of different medical specialties with the requirement-tracking questionnaire – a pilot study to provide a framework for medial students' choice of postgraduate training', BMC Medical Education volume 21, Article number: 46 (2021)- open access

[10] AIHW, 'Chronic Conditions' [online]; Chronic conditions - Australian Institute of Health and Welfare (aihw.gov.au), 17 June 2024

- How comfortable the GP will be to undertake an assessment knowing the legal implications of identifying impairment in a senior colleague.

- Erosion of trust and the existing therapeutic relationships between GPs and physicians – this is vital for the care and wellbeing of doctors.

The RACP calls for the MBA to commission a cost-benefit and cost-impact analysis of the GP assessment model compared to independent medical panels and professionals, including terms of reference on the opportunity cost for the already under pressure primary healthcare system. There could be significant benefits to late career doctors, GPs and the community by establishing independent panels to conduct individualised health assessments specific to scope.

A number of members raised potential concerns about age-related discrimination. It is important that a final decision on any health check model provide clear and compelling explanations of why such a model is not considered to be discriminatory.

Support for later career medical practitioners (questions 5-6)

With a more proactive regulatory approach comes the responsibility to promote the care, rehabilitation and ongoing practice of later-stage career medical professionals.

A proactive approach would have the MBA:

- Providing information on supports should a health assessment identify a scope related impairment, including clear referral pathways for further assessment and supports of the doctor, both professionally and personally.

- Providing protocol-based resources and educational packages on specific scope assessment processes and the introduction of mandatory training for assessors to assure consistency and impartiality. Any educational package produced must be clear on the distinction between a health condition and impairment within scope of practice, with due consideration to adaptive and environmental supports in place to mitigate risk as a key factor.

- A process for review or appeals for assessed medical practitioners to allow transparency and fairness, or discussions of in-workplace adjustments or alterations of scope of practice, is needed. Late stage-career doctors must feel supported to continue to provide safe care throughout their working lives.

The MBA should be measured in its reporting requirements, requiring assessors to issue to the late-stage career practitioner and return to Ahpra a standard certificate of capacity which should not disclose any personal medical details, consistent with approaches in other industries.

The MBA should implement a proactive strategy to mitigate the risk of complaints about late-career doctors who may have physical or cognitive impairment affecting their judgement or decision making and resulting in non-disclosure to the Board.

There should be continuing adherence to current mandatory notification protocols with no additions. Where an impairment is identified that would classify as a mandatory notification matter or a practitioner's impairment may prevent them from reporting a mandatory matter to the Board, the status quo reporting framework should apply with adequately designed support,

appeals and review processes in place. There should be no other circumstance in which a late-stage career medical professional's personal information is disclosed.

Other inclusions (questions 7.1-7.3 and 8.1-8.5)

While the draft resources are clear, they will not facilitate focused assessment of health domains linked to competence in specific scopes of medical practice. The resources provide limited support or training to the assessing party, and lack provisions for the personal, rehabilitative and adaptive support of the assessed practitioner. Whilst the MBA does not propose to offer training, there is potential merit in developing focused online training for GPs undertaking the checks to build on resources.

Assessment costs and payment considerations

The costs of the proposed health checks and who will bear these have not been clarified. Would costs for example, be covered within the pooled costs of existing registration fees, by a blanket increase to registration fees, by a specific Government rebated Medicare item, or be expected to be borne by the assessed practitioner? The same cost concerns extend to related supportive interventions, referrals and pastoral supports provided to the assessed practitioner.

When taken together, the costs of the process could be very significant depending on the referral pathway required for an individual practitioner should further examination or support be required.

Medical practitioners already bear significant costs in the maintenance of registration, purchasing of professional indemnity insurance, undertaking continuing professional development and other ongoing practice costs. There can also be income disparities between medical disciplines, and between practitioners in differing geographical areas.

The costs of assessment should they fall to practitioners may be compounded for later career medical practitioners who have reduced working hours.

Cost should not deter experienced and highly knowledgeable late-stage career medical professionals continuing in our health system, to physician trainee and patient detriment.

Concluding remarks

We thank the MBA for this opportunity to comment on this important matter.

We welcome continued engagement to ensure that any health checks for late-stage career medical practitioners are effective, efficient and supportive of physicians, and that our various physician specialties can contribute their important specific expertise around health checks.

Please contact Peter Lalli, Senior Policy & Advocacy Officer, for questions or comments about this submission via email: policy@racp.edu.au