Your details

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Organisation (if applicable): Royal Australasian College of Surgeons

Are you making a submission as?

- ☒ An organisation
- ☐ An individual medical practitioner
- ☐ Other registered health practitioner, please specify:
- ☐ Consumer/patient
- ☐ Other, please specify:
- ☐ Prefer not to say

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- ☒ Yes, with my name
- ☐ Yes, without my name
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Feedback on the Consultation regulation impact statement

The Medical Board of Australia is consulting on three options to ensure late career doctors are able to keep providing safe care to their patients.

The details of the options for consideration are contained in the consultation regulation impact statement.

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?

Ageing is related to cognitive and physical decline. Most countries have no mandated retirement age for surgeons. Screening and assessment programs are often suggested as an alternative to the adoption of a mandatory retirement age for surgeons. Continuous monitoring of a doctor's needs and cognitive and physical abilities throughout their career, regardless of age, would identify early signs of physical or cognitive decline. A small number of other occupations do enforce screening or retirement ages for their constituents, for example, members of the armed forces and federal judges in Australia.

In preparing this response, RACS completed a rapid systematic review (September 2024). For clinical specialists, including for surgeons, there are relatively few published programs globally (n = 21) to assess or monitor doctors as they age, and no single standardised program exists. Most published programs are comprehensive, including a health check and an assessment of cognitive and physical performance.

Of the 21 programs identified globally, 8 were voluntary, unclear or had no explicit requirement for the health check (US). For these programs, the health checks were not obligatory but were recommended or suggested for those age 65–70+, or those who received referrals to the programs based on specific policies and procedures of the referring medical centres. National bodies (e.g. American College of Surgeons, British Medical Association) discuss issues related to flexibility, transition planning and support for the ageing workforce, and whole-of-career testing

RACS strongly supports initiatives that aim to improve health and well-being across all populations in Australia and Aotearoa New Zealand including medical practitioners. We recognise the importance of preventative measures, including regular health checks and screening tests, in maintaining good health and reducing health burden.

RACS is supportive of regular health checks for all doctors, including registered late career doctors.

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?

RACS recognises that each doctor's cognitive and physical health is unique to them and understands the challenges involved in seeking to apply a commencement age for health checks.

Evidence from our rapid systematic review found that 17 of 21 programs had a specific age for the health check with:

- 13 at age 70 years, 4 were at age 72 or 75 years.
- 2 programs (US) also included a trigger for referral, based on policies, procedures or reasonable concerns.

RACS understands the motivation to commence health checks at 70, as supported by published Australian notification data. RACS is supportive of a triennial health check for doctors 70-79 years and annual check for those over 80 years but given the sparsity of comparable initiatives we ask that a monitoring and evaluation framework be established.

This would help to ensure correlation between age, health checks and risk is subject to on-going validation and systematic continuous improvement. It also recognises that many Australians (including surgeons) are living and working longer, providing a sound evidence base for future adjustment to the age threshold/s.

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.

During our rapid review the nature of the published and proposed assessment varied, as did the detail in which the components were described:

- Most programs, where reported, had a frequency of 2–5 years (9/21). There were 2 annual programs (US), and 10 programs were unclear on the frequency of assessment.
- Most programs included a general health check (4/21 were unclear or did not provide a general health check).
- One program was restricted to computer-based screening of motor and cognitive function.
- One program required an annual fitness-to-practise assessment by a credentialling committee.
- Some programs (n = 9) included a review of performance, including review by their peers.
- Many programs (n = 16) were comprehensive and included cognitive/dexterity testing and assessment of physical health.

Doctors are important role models and advocates for preventative and screening measures in our communities. We recognise the importance of showing leadership in maintaining our own health and well-being. The Professional Performance Framework (2017) identified the likely introduction of late career health checks under Pillar 2 - Active assurance of safe practice**.** While RACS does not support age alone as a defining factor on a doctor's ability to practice, we recognise maintaining

the status quo (Option 1) does not address concerns about higher rates of notifications for late career doctors.

In considering Option 2, when canvassing our members there was some support for this approach. While RACS accepts there are a number of benefits to a fitness to practise model, we hold concerns about the capacity of our occupational and environmental health colleagues to deliver these assessments given existing workforce challenges. On reviewing the evidence provided through this consultation, the cost implications of this option are also significant. With limited evidence of other successful programs in Australia or internationally available at this time and with health budgets and resourcing already stretched, RACS holds reservations about the feasibility of this model.

RACS is supportive of Option 3 and sees this as a viable option that provides opportunity for escalation where required. If implemented with a comprehensive monitoring and evaluation framework, there would be adequate scope to adjust in the future where required. The model is not without some significant limitations. It would be important to ensure that, as much as possible, assessments are free from bias and/or conflict of interest. We would ask that the Board consider whether an assessment should be undertaken by a clinician in that doctor's craft group or specialty (noting the draft standard has flexibility) and also whether there are any restrictions on the assessing clinician (i.e., should there be an upper age limit).

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?

Evidence from our rapid systematic review found that:

- 17 of 21 published programs required a cognitive function test as part of the screening
- 1 program clearly stated that a baseline assessment should be undertaken (at age earlier than 65 years).

Surgeons are regularly assessed and monitored by their peers, workplaces, specialty or craft group and RACS. As a long-standing advocate for comprehensive audit as a mandatory component of CPD – including mortality audit – RACS notes that surgeons routinely participate in activity that monitors on-going competence including cognitive function. While acknowledging the importance of cognitive function, physical function and maintenance of dexterity is also significant for surgeons in operative practice

While noting that the rapid review found it to be a common feature of existing programs, RACS does not have a strong position on whether cognitive function screening to establish a baseline is essential for surgeons.

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.

RACS strongly supports assessments remaining confidential between the assessing clinician and the doctor. By maintaining confidentiality, doctors are more likely to speak openly about their health concerns resulting in improved health outcomes for the doctor. RACS supports the position articulated in the consultation paper that:

'…*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.*

We would also ask that the Board consider whether a trigger of reasonable concern should be a requirement, particularly if a mandatory specialist occupational and environmental physician assessment is required.

RACS notes the position on mandatory reporting:

'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.'

RACS is supportive that the monitoring of the health check requirement be undertaken during the annual registration renewal so as not to increase administrative burden.

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?

The majority of published programs were unclear regarding the active involvement of the board or oversight committee in health checks. Where the oversight group was more involved in the assessment, this was via a credentialling committee.

RACS believes the regulators role is to provide legislation, standards and guidelines to effectively monitor the profession and in particular complaints and notifications. We acknowledge the privileged position doctors in Australia hold with respect to self-regulation of our profession and we believe specialist medical colleges are well placed to support the implementation of this initiative. RACS has already recognised the importance of regular health checks as an activity in our CPD Program and see this as complementing the proposed standard.

Feedback on draft Registration standard: Health checks for late career doctors

This section asks for feedback on the Board's proposed registration standard: Health checks for late career doctors.

The Board has developed a draft Registration standard: health checks for late career doctors that would support option three. The draft registration standard is on page 68 of the CRIS.

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

The content and structure of the draft registration standard is clear and consistent with other standards. RACS appreciates the clarity of definition on what 'practice' means with regard to the proposed standard and specifically that is not restricted to the provision of direct clinical care.

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

RACS would ask for clarification on whether there are any other grounds for exemption from undertaking a health assessment in the pre-defined year. For example, if a practitioner was unable to complete the assessment due to ill health.

We also would ask whether the assessment has to be undertaken in Australia and/or by an Australian practitioner and if so, would an exemption apply due to an extended period overseas.

Late career doctors provide significant value to the health workforce, commentary on support for re-skilling or remediation may be helpful.

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

RACS acknowledges the considerable effort in preparing the draft registrations standard and thanks the Board for the opportunity to comment.

Draft supporting documents and resources

This section asks for feedback on the draft documents and resources developed to support Option three - the health check model.

8. The Board has developed draft supporting documents and resources (page 72 or the CRIS). 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.

   The materials are on page 72 of the CRIS.

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

The supporting documents are extensive. Where possible and given the detail of some of these documents, RACS would suggest highlighting key text to draw the readers attention. Particularly with respect to C1, C2, C3.

8.2. What changes would improve them?

Some readers may experience difficulty due to the sizable amount of information areas relevant to each other and that at times these appear disjointed. For example, possible consequences of failing an assessment and content on mandatory reporting for the treating practitioner could be clearly stated earlier in the document rather than in Appendix C towards the end.

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

The information as listed below is thorough and comprehensive.

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

The proposed pre-consultation questionnaire – while comprehensive and extensive – includes in excess of 100 questions with the majority being a yes/no answer. If a questionnaire becomes too long or confusing, respondents may be unwilling to complete it, or they may make mistakes (ABS). We would also question whether it can be completed to a high standard in 10 minutes as indicated at the start of the questionnaire.

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

RACS considered the proposed examinations and tools listed as appropriate.

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

The resources developed are thorough and comprehensive.