RURAL DOCTORS ASSOCIATION OF AUSTRALIA

# SUBMISSION TO THE MEDICAL BOARD OF AUSTRALIA

## Consultation on Health checks for late career doctors

## About RDAA

**The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and their patients and communities.**

RDAA is focussed on ensuring that excellent medical care – provided by a health workforce with the necessary training and skills to meet the diverse health needs of people living and working in rural[1] and remote communities – is available, accessible and affordable.

## Introduction

It is essential that policies and programs that actually work to rectify medical workforce maldistribution and other imbalances that contribute to rural health inequities in Australia are developed and implemented. This includes the development of registration standards that will impact on individual doctors and their ability to provide services. The impacts of medical workforce shortages and maldistribution are strongly felt in rural Australia. It is imperative that any standards are based on robust evidence and their development and implementation are considerate of the rural context.

While the notion of health checks for late career doctors – or any professionals where there may be profound consequences on the health, wellbeing and life of any person – and the development of a process to manage risk is a reasonable premise, there are a number of issues that are inadequately dealt with in the Consultation Regulation Impact Statement (CRIS), particularly for rural doctors.

RDAA is concerned that the rural context has not been adequately considered. Both Option 2 and Option 3 are underpinned by metrocentric assumptions. Many of the comments in this submission are related to Option 3 as it is clearly the preferred option. Despite being the least expensive and burdensome option from the perspective of regulatory bodies and metropolitan doctors, it still places significant impost on rural doctors, their practices, patients and the community as a whole. Any negative impacts on the supply of healthcare to rural communities must first be considered and appropriately mitigated before health checks for late career doctors are mandated.

[1] RDAA uses the term "rural" to describe areas classified as Modified Monash Model (MMM) 3-7. This includes remote and very remote places where the health needs are often greater and healthcare service delivery challenges most difficult. The MMM measures remoteness and population size on a scale of MMM1 (major cities) to MMM 7 (very remote).

## Summary

- Characterising the proposal as a preventative health measure that is linked to improving medical culture to prioritise doctors' health is disingenuous, and oversteps the regulatory functions of Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia (the Board).
- Although it is acknowledged that age-related declines in health affect doctors, the evidence presented is insufficient to support the proposal to mandate health checks for doctors aged 70 years and over through adopting the *Registration standard: Health checks for late career doctors* (the Standard).
- The described processes are metrocentric, and fail to take the rural context into account, including in relation to rural late career doctors' access to assessing/treating doctors and/or other health professionals.
- The development and publication of criteria that would qualify or disqualify a clinician from being able to practise is needed to ensure transparency.
- Given that there can be significant repercussions if a doctor does not complete or is found to be impaired, a transparent appeals process should be developed and made public.
- Specific and adequately resourced strategies that mitigate against unintended consequences to rural doctors, rural patients and rural communities must be developed and implemented. These consequences include disadvantage in relation to individual financial and other costs, and potential negative impacts on the rural medical workforce and health services.

## RDAA's Position

Commitment to the quality and safety of patient care should never be compromised.

RDAA acknowledges the reality of physical and cognitive decline as a function of ageing for many people, including doctors. However, if health checks for late career doctors are to be mandated, there must be unequivocal evidence that they are necessary and likely to improve patient safety and outcomes. The evidence provided in the CRIS indicates that that there are more complaints about doctors aged 70 years and older. However, given the range in types of notifications, generalising all notifications with reduced patient care and poorer health outcomes is inaccurate.

Before any definitive decision to mandate health assessments or checks for late career doctors is made

- the rationale for defining late career doctors as those aged 70 years and older must be made explicit
- the correlation between notifications and poorer patient outcomes must be better demonstrated
- the data underpinning the proposal must be re-examined to ensure that it from complaints that were both justified and due to doctor health issue/s that would be detected by the proposed health assessment or check.
- the cost benefit analysis must model the impact that mandating health assessments or checks on rural patients and communities should this lead to rural doctors ceasing to practise, and strategies to negate any adverse outcomes must be developed.

## Key issues

### Rural context

A rural lens must be applied when establishing a process to manage any risks associated with an ageing workforce. While commitment to the quality and safety of patient care should never be compromised, any regulatory change must balance identified risks with actuality. Unintended consequences must also be appropriately understood and addressed through strategies to reduce any negative impacts on an already stretched rural medical workforce.

Rural doctors have expressed concerns relating to the sufficiency of evidence provided in the CRIS, and whether proposed processes will address identified issues and be imposed fairly. The potential for this reform to unfairly disadvantage rural medical practitioners and their patients is disquieting.

In the CRIS, some impacts on the broader health sector are noted but it is suggested that there may only be a ***small number of occasions*** [author emphasis] *where this would impact on the availability of doctors in particular regions,* and that it is *difficult to specifically attribute this to the outcomes of a health check, compared with the general propensity to retire with increasing age* (p56). No reference is provided for this conclusion.

Doctors aged 70 years and older practising in Modified Monash Model (MMM) 2-5 comprise less than 0.5% of the total number of practising doctors in Australia (604 of 132,366). In MMM 3-7, this percentage drops to a little over 0.3% (414 of 132,366).[2] It is acknowledged that the number of doctors in this cohort (over 70, in MMM2-7) is small. However, the impact of mandating health assessments or checks will be significant on rural health services and communities if multiple of these doctors cease practising.

Rural areas are underserved in relation to health care, and continue to be greatly impacted by medical workforce shortages and maldistribution. An observable impact of this is the continuing and unsustainable reliance on overseas-trained doctors (International Medical Graduates). Late career doctors can and do have vital and valuable roles in maintaining local health services. Any initiative that is onerous to undertake, costly, and offensive for some, could have significant unintended consequences for the provision of these services.

Health facilities in rural communities are heavily reliant on their current workforce. They are often one resignation (retirement) away from a workforce crisis and at risk of having to downgrade or halt service delivery if doctors stop practising earlier than planned. If a general practice closes, there may not be another within the vicinity which can impact upon patients' ability to access primary care as close as possible to their home. Rural hospitals are also often staffed by local rural GPs/rural generalists so the operation of these services would also be significantly impacted. This would be a significant cost to the community. The engagement of locum services to address any workforce gaps is a costly exercise. Locum services could also be impacted if those late career doctors who have chosen to provide locum services as they change their work commitments in the lead up to retirement cease to practise entirely.

The reasons why rural doctors continue as practising late career doctors vary. RDAA has been advised that it is often to do with reluctance to leave when the likelihood that they can be easily

[2] Drawn from data provided in the CRIS.

replaced is doubtful. The advent of the COVID-19 pandemic and its impact on the rural medical workforce, and the decimation of general practice services in areas that experienced devastating floods or bushfires, have also led to doctors delaying retirement. If the proposed health assessments or checks place a considerable financial or other impost on doctors, they may choose to cease practising. This would leave their patients and communities with no or limited medical care nearby.

There is also concern about the impact that mandating health assessments or checks could have on the physical and mental health of individual practitioners and on the rural health workforce as a whole.

The statement that *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* (CRIS p55) does not reflect the reality of access to health care for rural doctors. Outreach services are not available for all rural areas, and some health assessments or checks cannot be completed entirely via telehealth. This would result in rural doctors having to travel to undertake the assessment/check, placing additional financial burdens (such as transport, accommodation, loss of income and cost of a locum) on these doctors. This is especially concerning for doctors working in isolated practice (such as in rural and remote communities and/or in solo practice).

It is imperative that the rural context be considered in the development and implementation of any initiative requiring health checks for late career doctors. This includes identifying strategies that can be integrated into registration and credentialing processes to mitigate any impact on rural practices, patients and communities (for example, health status attestation at registration and renewal).

If health checks are to be mandated, strategies to reduce the burden on late career rural doctors should be put in place. For example, independent physicians could be funded to provide outreach services specifically for the required health check to rural doctors). This is essential to mitigate against any potential negative impacts on the rural health workforce and health services.

## The roles of Australian Health Practitioner Regulation Agency and the Medical Board of Australia

The roles of Ahpra and the Board as regulatory bodies are to: develop and publish regulatory standards, codes, guidelines, updates and other resources; manage practitioner registration; ensure that practitioners are appropriately trained, qualified and safe to practise; manage compliance; and deal with complaints[3]. There is concern that they are overstepping these roles. As regulatory bodies they must maintain distance from the processes for which they are responsible.

Processes to safeguard public safety and manage risks to patients are within the purview of Ahpra and the Board and are clearly the underlying driver for the proposed action. This should be explicitly stated. It appears that the introduction of regular health assessments or checks for doctors aged 70 or older is to manage the perceived risks rather than "building a better culture that prioritises

[3] *The Medical Board of Australia's purpose is to ensure that Australia's medical practitioners are suitably trained, qualified and safe to practise. Public safety is our priority. The Medical Board of Australia supports safe practice by publishing regulatory standards, codes, guidelines, updates and other resources for doctors, employers, students and the public.* https://www.medicalboard.gov.au

doctors' health". This makes the Why is government action needed? claim[4] and other statements about encouraging doctors to take responsibility for their own health" (for example, CRIS, p56) somewhat disingenuous. Mandating a course of action is more than encouraging it. If improving medical culture is a key aim, then there must be engagement with medical students and all doctors throughout their training and careers.

Until such time that mandated health checks or assessments for rural late career doctors are clearly proven to be necessary, consideration could be given to other options to strengthen the existing system and doctor compliance, for **all** doctors not just late career doctors. Ensuring engagement with doctors throughout their careers (commencing in medical school) is more likely to improve medical culture in the longer term.

For example, the existing system could be reinforced by:

- developing a statement on health (based on provided specific health criteria but not on a mandated health check) that could be attested to at registration/renewal by all doctors, including late career doctors.
- making further assessments and/or testing available but not mandatory.

This could be supported by other stakeholders:

- providing increased education on self-care and medico-legal responsibilities and consequences at all levels of medical training. This includes supporting medical educators and supervisors to provide this training, including through the development and dissemination of resources
- regularly communicating information on self-care and medico-legal responsibilities and consequences to all practising registered doctors.

## Evidence

The rationale behind defining late career doctors as those who are 70 years of age or older and choosing that as the point at which regular health checks be required is not clear. This should be made explicit. Much of the background information is related to doctors who are aged 65 years or older. However, information on notifications related to the 65-70 years age bracket is not provided.

There is an underlying assumption that doctors aged 70 years or older do not access regular health care adequately which means that they are not compliant with the *Good medical practice: a code of conduct for doctors in Australia*. The evidence presented about the reluctance to consult other doctors is not specifically about older doctors. There may be a significant cohort of junior doctors, for example, within the 26 % per cent of doctors who reported feeling inhibited about consulting another doctor, or gender and cultural considerations may have a role. A better indicator would be the proportion of late career doctors within the 26 % who do not seek the care they need.
The suggestion that burnout is a particular issue for late career doctors (CRIS, p17) has little to substantiate it. The pressure that results in burnout in the medical profession is caused by a range of

[4] *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 culture that prioritises doctors' health and reduces the related risk to patients*. (p31 CRIS)

factors and affects doctors at all stages of their careers. There is insufficient analysis given to warrant assumptions about the health behaviours of older doctors.

No consideration of peer regulation through informal and formal mechanisms (such as hospital credentialing committees) is evident in the CRIS. Academic regulation (standards to meet ongoing fellowship requirements) has also not been included.
There is also an assumption that regular mandated health assessments to demonstrate fitness to practise (Option 2), or mandated general health checks (Option 3), will identify an increased number of late career doctors with significant health issues that need further investigation and proactive management. This may possibly be true in some circumstances, but only if doctors in that age group are not already pro-actively managing their health issues. The evidence presented to suggest that there are a sufficient number of doctors who have untreated/unmanaged health conditions that impact on patient safety and health outcomes relies on the increasing notifications data to support the proposal. There are a several issues with this:

- The 2015, 2019 and 2023 notifications data, does not provide an analysis of the underlying reasons for the increase in notifications. Reasons other than declining physical and/or cognitive health, including any changes in reporting requirements or employment conditions impacting on doctor performance, have not been noted in the CRIS.

- It is unclear whether there are other factors contributing to the increased number of notifications and if these factors have been investigated. It may be that patients and their families/carers are more informed about their rights and the processes for ensuring that their care is appropriate – this information is becoming more easily available with better digital access – and they are, therefore, more likely to make a complaint. This would be a positive if it leads to better patient care and outcomes but there are many types of notifications, not all of which result in poorer patient care and outcomes.

- While the evidence presented on rates of chronic illness, and physical and cognitive decline as a function of ageing is not disputed, it should be noted that the increased number of notifications does not necessarily equate with diminished capacity to provide safe care among older doctors. As noted in the CRIS, this is variable. There is no actual statement or evidence presented about the relationship of complaints to relevant patient outcomes. This correlation is assumed but not measured.

  In an increasingly litigious health environment, it is important to acknowledge that complaints may be frivolous or vexatious in nature, and that impact of social media and the spreading of misinformation (deliberate or otherwise) may also be a factor in such complaints. Fear of being sued may also be a factor in complaints from other sources, such as employers.

  The type of complaint (for example, whether it is about poor clinical care or some other issue such as inappropriate behaviour unrelated to patient outcomes), the source of notifications and any increased notification trends related to type and source would provide a better indication of whether there is a need for mandating health assessments or checks for late career doctors.

- Figure 10 (CRIS p23) indicates that while the percentage of regulatory action taken as a result of notifications about doctors aged 70 years or older is higher than for younger doctors, none of the three most serious types of action were taken for this group.

- Analysis of the problem and evidence does not distinguish between general practitioners (GPs), rural generalists (RGs) and consultant specialists, nor does it breakdown notifications by procedural or non-procedural practice. Within general practice, there is often a change in the way that doctors practice as they age. They may have a planned exit strategy, stepping down particular activities and utilising their experience in different ways. They may reduce their procedural work and increase chronic disease management and mental health support. They may take on alternative roles or challenges, including supervision of trainees and academic or other pursuits. They may also decrease their hours of work.

- While the geographical distribution of late career doctors across Australia, using the MMM is provided (CRIS Figure 5, p14) there is no information about notifications by geographical distribution to indicate the degree to which the perceived problem is of concern in rural areas.

### Processes

Any proposed health assessments or checks for late career doctors must be underpinned by robust and transparent processes to ensure that they are appropriate and fair.

This should include the development and publication of criteria that would qualify or disqualify a clinician from being able to practise. This would mitigate against any possible conclusions about a doctor's health/fitness to practice being based on interpretation or personal relationships and feelings.

Implementation strategies must include ironclad mechanisms to ensure privacy and confidentiality. This is a real concern in small places, where your regular GP may also be a colleague/friend. Providing funded access to an independent physician would mitigate risks.

Governance processes, including for appeal and review, must also be clearly articulated and transparent. Given that the possible outcomes of the failure to meet the Standard can include placing a condition or conditions or refusing registration/renewal, fairness dictates that an appeals process is developed and links provided within the Standard. Links to appropriate processes, including appeals processes, if the health check leads to the identification of any declarable impairment should also be included.

The CRIS notes that, under Option 3, GPs already conduct health checks for people who are over 75 years of age and therefore *education is not required for the assessing /treating doctors, but may need reassurance about the limits of their role* (CRIS p63). *The Board is not proposing mandated additional certification or training for those conducting health checks.* (CRIS p 39). Also under Option 3, although the need for resources and educational packages to be provided to support GPs is recognised, actually using those resources and educational packages will not be required. While there is a cost implication, there is a risk that the health check processes will be poorly adhered to if education and training is not required.

How these decisions will impact on the rollout of health checks for late career doctors (if it proceeds) must be a focus of future evaluation.

## Costs

The assumptions underlying the calculation of costs are metrocentric. The do not take into account the increased costs for rural and remote doctors to comply. For these doctors the time commitment goes beyond the average 3 hours (Option 2) or 2 Hours (Option 3) because of the need to travel to appointments. There is also an additional financial burden related to transport and accommodation costs; lost income when away from their practice; and, in some cases, locum costs.

The time impost has also been underestimated as it does not include the associated administrative burden of compliance which is likely to be more than the estimated one minute to answer an additional question at registration/renewal (CRIS p45). It may include the gathering together of required related health information (such as from an optometrist) and certification as true and correct if needed. Completing these activities can be more complicated and time-consuming in rural areas. Undertaking any additional checks or testing that may be required has further time and financial costs that should be acknowledged.

Under the proposed options the majority of costs will be borne by the individual doctors. Even if, as noted in the CRIS, some of the costs may be defrayed by the existence of outreach and telehealth services for some parts of the health check, the costs to rural and remote doctors will be significantly higher. Some costs may be covered by the Medicare Benefits Schedule (MBS), but whether current rules in relation to health checks mandated for work purposes are applicable requires clarification. The health check may need to be fully privately funded. Even if MBS rules allow for the claiming of a rebate, it should not be assumed that practitioners will bulk bill their colleagues. They may choose to do so but it should not be expected.

Under Option 3, the Board clearly has no expectation that additional training and/or certification for assessing/treating doctors will be needed. However, resource development and some training may be required to ensure assessing/treating doctors are:

- familiar with the Standard and required documentation
- familiar with resources and educational packages developed (for the doctor undertaking the health check and for the assessing/treating doctor.
- understand the limits of their role
- are able to manage sensitivities associated with providing a service which could have major ramifications for their colleague/s and potentially compromise the trust relationship between the doctor and their regular GP or other health professional).

This may entail additional costs, including time (even if the training is provided free and online), lost income and potentially travel and accommodation. Treating/assessing doctors should be remunerated appropriately.

## Evaluation

The Board generally reviews its registration every 5 years by undertaking *preliminary and public consultations to assess the stakeholder, doctor and consumer* ***opinion*** [author emphasis] *of how the standard has been operating and proposed changes to it*. (CRIS p63). If the Standard is introduced, ongoing and close monitoring of notifications and any correlation of complaints with patient safety issues and negative patient health outcomes should be undertaken to assess whether the mandating

of health checks is having the desired impact. Evaluation and review should be based on empirical data.

## Conclusion

Before any decision to mandate health checks for late career doctors is made, the impact of mandated health assessments or checks for late career doctors needs to firstly be understood within the rural context. This includes the impact on rural doctors, rural health services, rural patients and rural communities. If the proposal is adopted, specific strategies to mitigate against any negative outcomes in rural areas must be developed and rolled out in conjunction with the Standard.