SPS Educational Program
Saturday, June 7 (12 noon – 1:30 pm)
Evaluating Impairment in the Senior Physician: Assuring Patient Safety and Physician Well-Being
Speakers’ Disclosure

The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, there are no relevant financial relationships to disclose at this time.
Objectives

At the end of this activity, physicians should be able to:

1. List changes in cognition that are associated with the normal aging process.

2. Appraise some potential screening assessment tools for the elder physician population.

3. Summarize the continuum of services to support physicians as they transition into retirement due to compromised capacity.
Speaker:
David E.J. Bazzo, MD

Clinical Professor, Family Medicine, University of California, San Diego School of Medicine
What we will cover

1. Describe the evidence regarding physician clinical performance as it relates to aging
2. Identify factors (other than aging) that affect clinical performance
3. Discriminate screening evaluations for competency assessment versus “for cause” assessment
4. Describe screening tests used to assess health issues affecting physician competence.
5. Compare experiences of various age-based screening programs
Polling Question #1

Do you believe that there is a need for age-based physician screening?

1. Yes
2. No
3. Maybe
Polling Question #2

If so, when should age-based screening begin?

1. Age 60
2. Age 65
3. Age 70
4. Age 75
5. Age 80
AMA Masterfile: Physicians Past, Present and Future

• 1985
  – Number in active practice = 476,683
  – Mean age = not known
  – % 65 or older = 9.4

• 2005
  – Number in active practice = 672,531
  – Mean age = 50.0 (SD = 11.4)
  – % 65 or older = 11.7 (n = 78,340)

• 2011
  – Number in active practice = 697,340
  – Mean age = 52.5 (SD = 11.4)
  – % 65 or older = 15.12 (n = 105,464)
Estimates Continued

• Projected number of active physicians in 2020 AMA Masterfile:
  • AMA = 1,050,000
    – 65+ = 189,000 (18%)
    – 55+ = 409,500 (39%)
Screening Test vs. Diagnostic Test

- Screening tests are offered to asymptomatic people who may or may not have early disease or disease precursors and test results are used to guide whether or not a diagnostic test should be offered.

<table>
<thead>
<tr>
<th></th>
<th>Diagnostic test</th>
<th>Screening test</th>
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<tbody>
<tr>
<td>Result</td>
<td>The cutoff is set towards high specificity, with more weight given to diagnostic precision and accuracy than to the acceptability of the test to patients</td>
<td>The cutoff is set towards high sensitivity. As a result many of the positive results are false positives. This is acceptable, particularly if the screening test is not harmful or expensive.</td>
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<tr>
<td>Cost</td>
<td>Patients have symptoms that require accurate diagnosis and therefore higher costs are justified.</td>
<td>Since large numbers of people will be screened to identify a very small number of cases, the financial resources needed must be justified carefully.</td>
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<tr>
<td>Result of the test</td>
<td>The test provides a definitive diagnosis (e.g. a definite diagnosis of Meningitis through blood test or lumbar puncture.</td>
<td>The result of the test is an estimate of the level of risk and determines whether a diagnostic test is justified.</td>
</tr>
<tr>
<td>Invasiveness</td>
<td>May be invasive.</td>
<td>Often non-invasive.</td>
</tr>
<tr>
<td>Population offered the test</td>
<td>Those with symptoms or who are under investigation following a positive screening test.</td>
<td>Those at some risk but without symptoms of disease.</td>
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Paradox of Aging

• Physical health and some cognitive abilities decline with aging, while your own impression of how successfully you are aging, mental health, and psychosocial functioning tend to improve

• Positive psychological attributes such as optimism, resilience, compassion, and wisdom do not decline with age, but stay stable or even increase in subgroups of individuals in later life

• Heterogeneity: Some seniors age more successfully than others
Greater Wisdom With Aging?

- New learning is possible, and older adults continue to exhibit new forms of adaptive capacity (Baltes & Baltes, 1990)
- Aging is associated with greater happiness, better mental health, and better management of interpersonal relationships (Helmuth et al., 2003; Jeste et al., World Psychiatry, 2010)
- Components of wisdom, such as social reasoning, increase with age—despite decline in fluid intelligence (Grossman, et al., PNAS, 2010)
Aging Physician

Physicians are among those special groups who operate in an environment unforgiving of human error, where cognitive failure can lead to catastrophic consequences.
Pilots vs. Physicians

• **National standard**
  – All pilots must maintain currency exam, simulation, and medical exam (frequency of latter varies with age: age 40 = 6 months vs under 40 = 12 months)

• **No national standard**
  – All physicians must maintain (generic) licensure to practice
  – No health assessment required
  – No assessment of competence, currency, or quality performance required in area/scope of practice
Characteristics of Aging That May Affect Clinical Competence

- **What we know:**
  - Physical-motor capabilities (dexterity), stamina, energy, strength, reflexes (reaction time), acuity of vision (visuospatial skills) and hearing, immune capacity, propensity for illness
  
  - Mental memory (short term), diminution of risk taking, impairment of puzzle and problem solving (information processing), reduced ability to adopt new ideas and/or reexamine old ideas
Other Risk Factors That May Affect Clinical Competence

- Poor performance in medical school
- Solo practice
- Lack of hospital privileges
- Lack of ABMS board certification
- Out-of-scope practice
- Clinical volume
- New knowledge/procedural skills
- Fatigue/stress/burnout
- Health issues—mental and physical—may or may not relate to aging
Old vs. Young: Diagnostics

- Old make more accurate initial diagnosis—rely on experience and non-analytic thinking
- Young take longer to make diagnosis—rely more on analytic reasoning
- Problem: 40% of initial complex diagnosis may be incorrect
- Can the older physician be taught to abandon first impressions and use more analytic reasoning?
- Objective peer feedback
Clinical Experience and Quality Healthcare

• Clinical practice outcome data is less consistent (with age), knowledge data is most consistent

• Retrospective review-selection bias; articles span 30+ years with more recent ones suggesting better outcomes

Cognitive Functioning and Age in Surgeons

• Cambridge Neuropsychological Test Automated Battery (CANTAB): Stress tolerance, psychomotor function, and visual-spatial functioning related to surgical skill

• Majority (60%) of senior active surgeons performed at or near the level of their younger peers on all cognitive tasks, as did 50% of retired surgeons

Drag et al. J ACS 213:303, 2010
Age and Operative Mortality
U. of Michigan, Greenfield

• Medicare 460,000 patients undergoing procedures between 1998 and 1999
• Pancreatectomy, CABG, carotid endarterectomy, esophagectomy, cystectomy, lung resection, aortic valve replacement, and AAA repair
• Age related (> 60) mortality increased only in pancreatectomy, CABG, and carotid surgery, but restricted to older surgeons with lowest volume

Competency literature

- 683 physicians referred for assessment
- Factors predictive of unsafe assessment outcome
  - Older physicians were more likely to have unsafe assessment outcomes ($P < .001$)
  - Physicians in solo practice ($P = .037$)
  - Current or previous board action ($P = .003$)
- Protective factors
  - Board certified individuals ($P = .003$)
  - Practice scope that matched their training ($P = .023$)
Responsibility: Societal/Professional Contract – 19th C

- As a self-regulated profession, medicine is granted substantial societal privilege and, in return, is expected to set standards for entering practice, for sustaining privilege to practice, and for sanctioning and removing from practice physicians (5%–10%) who neglect or abuse that privilege.
Responsibility

- 96% of physician responders agreed that impaired or incompetent physicians should be reported to the appropriate authorities.

- 45% reported that they had encountered such colleagues and failed to report incompetent colleagues.
What We Know/Assess Today: ABMS/ACGME Competencies

- **Medical knowledge**: Multiple-choice tests, oral exams, OCE, chart reviews, simulations
- **Patient care**: Performance (real or simulated), mock patients, orals, chart review
- **Practice-based learning**: CME
- **Interpersonal communication skills**: 360, observation at test site, chart review
- **Professionalism**: Chart audit, 360, mock patients, ethics exams
- **Systems-based practice**: Oral exams, chart audits
- **Also**: Health, neuropsychological
- **Necessary, but not sufficient**
What We Need to Know
From Where and From Whom Will It Come?
Local/Regional, State, and National Organizations

• Evaluation of mental and physical health regularly and increasing in frequency after age 55 or when illness develops. Neuropsychological testing as necessary.
• Reliable assessments of actual performance or reliable and relevant proxies for performance that measure outcomes or processes and provide feedback and follow-up to document change.
• Re-credentialing (annual), licensure/re-licensure based on actual scope of practice (2 years) and recertification/MOC (3 years).
• Technical/procedural skill: Simulators/proctoring for new operations to document proficiency and after age 60, or if illness has developed. Specialty-specific and based on practice profile.
Unintended Consequences of Age-Based Competence Decisions/Mandatory Retirement

• Contribute to predicted physician shortfall as population ages and their needs for medical care increase
• Loss of contributions of medical wisdom and experience
• Economic losses: society paid for medical education; delaying retirement
• Beware the “law of averages”—old does not necessarily mean incompetent
• Age may be a risk factor, but it is not the only one
• Age Discrimination in Employment Act (ADEA)
# What Can We Do? – 3 Policies

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<th>Hospital/group</th>
<th>Screening commences at age</th>
<th>Frequency of assessment</th>
<th>Areas assessed</th>
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| Stanford Lucile Packard Children’s Hospital | Age 75                    | Every 2 years           | • Peer assessment of clinical performance  
• History & physical  
• Cognitive screening |
| University of Virginia Health System   | Age 70                    | Every year after age 75 | Physical and mental capacity (not defined further)                             |
| Driscoll Children’s Hospital           | Age 70                    | At reappointment        | • Physical and mental examinations (described elsewhere)  
• Proctoring of clinical performance if deemed appropriate |
What Can We Do?

- **PACE Aging Physician Assessment (PAPA)**
  - PACE intake form
  - History & physical exam
  - Vision, hearing
  - Screen for substance abuse and depression
  - MicroCog®

- **PILOT study – 2014**
Speaker:
Mary Yarbrough, MPH, MD
Associate Professor, Internal Medicine &
Assistant Professor, Preventive Medicine
Vanderbilt School of Medicine
What we will cover:

• Identify the challenges of providing healthcare to physicians

• Overview a strategy for providing workplace behavioral care

• Discuss behavioral care of the aging physician
Difficulty in Treating Physicians

- Afraid to show weakness
- Denial: feel immune to disease
- Minimize and intellectualize symptoms
- Delay seeking treatment
- Tendency for self-treatment

Rovold, AHRQ Medicine Sept 2004
Pitfalls of Caring for Physicians

- Provide
  - “VIP treatment”
  - “Curbside Consultations”
  - Insufficient, or over extensive, examination
- Over-identify with “patient”
- Give inadequate information
- Take little responsibility for care
Behavioral Management in the Hospital

• Joint Commission requires formal process for managing unacceptable behavior separate from disciplinary process.
THE EAP Model

Assist in resolution of personal problems that impact the workplace

• Behavioral
• Emotional
• Relationship
• Addiction
Role Clarification Within the Organization

- Physician Supervisor
  - Decision Maker
  - Focus on job performance
  - Enforce policies/bylaws
  - Avoid counseling for personal problems or minimizing problems
  - Determines need for disciplinary and/or behavior actions

- Physician “EAP”
  - Assess behavioral problems
  - Develop “Plan of Action Plan”
  - Advise supervisor
  - Coordinate communications
  - Monitor
  - Maintain Confidentially
  - Determine if safe to practice
Number of Cases by Age and Referral Type in FY14
Primary Presentation
(percent)

- Psychological: 59%
- Workplace: 16%
- Relationship/Family: 16%
- Addictions: 4%
- Financial: 0%
- Other: 4%
Faculty and Physician Wellness Program
Continuum of Services

Assessment
Problems and Needs
Plan for Care

Skill Development
Performance
Solution Focused Counseling
Psychotherapy /Medication
Rehabilitation and Monitoring
Dr. Smith: 68 yo male

• Dr. Smith, the department chairman, called to discuss a female physician who complained she was not being supported.

• Dr. Smith had intervened when the female physician had reprimanded a junior colleague under her supervision. She complained that Dr. Smith had a pattern of undermining her authority.

• This was the fourth incident where a female physician had complained about lack of support. Dr. Smith was frustrated. He did not have this problem with “the guys”.
Skill Development

• Skill: Learned capacity to achieve expected results with minimal effort.
• ASTD/DOL: 16 basic skills for today’s workplace, e.g.
  – Communication
  – Group effectiveness
  – Interpersonal (e.g. coping, teamwork)
  – Leadership
  – Organizational (e.g. time management)
  – Problem solving
  – Career development
Dr. Doe: 67 yo male

- Dr. Doe was referred to the FPWP following a poor performance review. Dr. Doe had “always been a good physician but could be a bit prickly”.
- The nursing staff complained that Dr. Doe did not follow the new safety protocols put in place on the unit. At division meetings the chief reports he comes in late and is unprepared.
- Last year Dr. Doe was passed over for the division chief appointment. He has never accepted the younger supervisor who lacks experience. He says he wants to get along “but……”
Performance Coaching

• Help achieve personal goals
• Overcome barriers
• Motivate to maximize personal and professional potential.
Dr. Adams: 71 yo male

- Dr. Adams is an is a senior physician actively involved with residents. This year he received poor reviews. Others have reported he is distant and “off his game”.

- Dr. Adams is well respected and considered a “pillar” of the community. He helped start the department and was the chair.

- Dr. Adams asked to speak with a physician from the FPWP. He shared that his wife has a severe drug problem and refuses help. He wants out of the marriage yet they had been together since before medical school. He does not know how he feels about her anymore.
Solution-Focused Counseling

- Short-term focus on solving a specific problem
- Emphasis on coping and adjusting to a life challenge
Dr. Jones: 65 yo male

- Dr. Jones has been in practice over 35 years. His patients adore him. His practice joined a larger hospital-based practice and the contractual arrangement allowing his practice some autonomy has expired.
- There were cutbacks that Dr. Jones feels will adversely impact patient care. He has complained to nurses and patients. He has had outbursts at staff meetings. The week prior he sent a scathing email to all senior leadership, claiming they were “going to murder the innocent”.
- Upon referral he shared that he has a long history of depression and quit taking his medication a year ago. “Things are just not what they used to be.”
Psychotherapy and/or Medication

- Psychotherapy: Treatment of mental and emotional disorders through techniques designed to encourage communication of conflicts and insight into problems
- Medication: Primary or supplemental pharmaceutical treatment for mental disease
Dr. King: 86 yo female

• Dr. King has a career spanning over 6 decades. She has a distinguished career. Her co-PI says that she is forgetful. He feels she is a safety threat. She has gone into the MRI several times with a watch. Others have noted her forgetfulness.

• Dr. King has a husband who is 10 years her senior and an invalid. She has no outside interests. She is very articulate and reports other’s “slips”.

• Her PCP has cared for both she and her husband for years and sees absolutely no problem.
The Continuum of Services: Dr. King’s Course

- Removal from work until safety to practice determined
- PCP meeting (with releases)
- PCP ordered neuro-psychological testing
- Independent testing with
  - recommendations on safety to practice
  - Identification of abilities related to practice
- Review with PCP
- Patient discussion and plan
- Family discussion with son in another city
- Social assessment and management
- Financial assessment and management
- Consideration of guardian
“Thus it is that scholars, even when endowed by nature with a jovial temperament, gradually become saturnine and melancholic.”

- Bernardino Ramazzini, Diseases of Workers (Translated from the Latin test DeMorbis Articum of 1713)
Facilitator:
Nancy H. Nielsen, MD, PhD
Senior Associate Dean, Health Policy,
University of Buffalo School of Medicine
Balancing Public Safety and Opportunities for Continuing Practice

Question 1:
Understanding that there are no easily available answers for assessment and treatment, what can the AMA’s role be in determining competency of an aging workforce?
Balancing Public Safety and Opportunities for Continuing Practice

Question 2:
Can guidelines be developed to help the various organizations and the public with these concerns?
Question 3: Remediation and how to keep senior physicians in practice. For example, broader and more coordinated strategy for a growing number of physicians in order to keep them in the medical workforce and make use of their experience.
Upcoming AMA Conference
June 19-20, 2014

‘Confronting the Challenges of Physician Fitness for Duty’

Coalition for Physician Enhancement (US and Canada) - group in the US and Canada that work on competency assessment issues.

Semiannual meeting focuses on various topics:

Next session will focus on the topic of fitness for duty and includes:

• Presentations
• Workshops
• Further discussion on the topic

For more information, please visit: http://cpe.memberlodge.org/