Aging Physicians: Balancing Patient Safety, Physician Reputation, and the ADEA

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Horty, Springer & Mattern
October 7, 2014
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Why is this topic relevant?

- In 2010, 24.4% of physicians were 60 or older
- In 2012, 26.3% of physicians were 60 or older
- More physicians delaying retirement
- Physician shortage predictions


Physical and Mental Effects of Aging
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Figure 4.1 Age-related decline in five physiological functions. VO2 Max = maximum oxygen consumption; SBP = percentage with normal systolic blood pressure; GFR = glomerular filtration rate; FEV1 = forced expiratory volume in one second; Cardiac = heart rate per minute during maximal exercise.

Figure 4.2 Age-related differences in MiniCog total score.

Figure 4.3 Age-related differences in memory, reasoning, and visuospatial ability of subjects aged 35-75 decline expressed in young adult (22-28) standard deviations. Source: Adapted from T. A. Stallhouse, Phenomenal Perspectives on Cognitive Aging (Halstead, NJ: Erlbaum, 1991).
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Estimates of Alzheimer’s Disease and Dementia

- 11% of those age 65 and older have Alzheimer's disease
- 14% of those age 71 and older have some form of dementia
- What about physicians?
  2014 Alzheimer's Disease Facts and Figures

Yes, but does any of this translate into poor patient care?

Choudry Study

- Identified 62 studies, 12 of which assessed knowledge, e.g.:
  - Indications for, and risks of, blood transfusions
  - Survival benefits of therapies for heart attacks
- 12 of 12 studies showed worse performance as age increased
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### Choudry Study

- Of the 62 studies, **43 assessed** adherence to standards of practice, e.g.:
  - Appropriate use of diagnostic and screening tests
  - Compliance with cancer screening guidelines
- **29 of 43** studies showed worse performance as age increased
- **2 of 43** studies showed better performance as age increased
- No relationship in other studies

### Choudry Study

- Of the 62 studies, **7 assessed** outcomes, e.g.:
  - Mortality rates for heart attack patients
  - Mortality rates for cardiac artery bypass grafting
- **4 of 7** studies showed worse performance as age increased
- **3 of 7** studies showed age had no effect

### Drag Study

**Rapid Visual Information test, Reaction Time test, and Paired Associates Learning test**

Cognitive Changes and Retirement Among Senior Surgeons, Drag et al, *J Am Coll Surg* 211: 3 (Sep 2010)
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Drag Study
Overall, “the senior surgeons performed significantly below the younger surgeons” on all 3 tests
However:
• 55% of the senior surgeons (over age 60) performed within the range of the younger surgeons on all three tests
• But only 33% (over age 70) of senior surgeons did as well as younger surgeons on all three tests

Physicians May Not Know When It’s Time to Quit
Some studies suggest that physicians who were least skilled, or most confident, were the least accurate in assessing their own skills

Accuracy of Physician Self-Assessment Compared with Observed Measures of Competence, Davis et al, JAMA, Vol. 296, No. 9 (Sept. 6, 2006).

So what should hospitals and medical staffs do?
Medical Staffs should evaluate their unique culture and decide if an age-based rule makes sense in their hospital.

Benefits of a Rule (e.g., a Bylaws Provision)

- Protect patients
- Reduce risk of negligent credentialing claims
- Treat all physicians the same (thus reducing risk of discrimination claims)
- Depersonalize issue

Drawbacks of a Rule

- Overly inclusive (affects physicians with no problems)
- Controversial and inconvenient
- Unnecessary if peer review process is working properly?
- Difficulty interpreting test results (especially if no baseline)
- Increased risk of discrimination claims
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Low Risk

• Adopt and enforce evidence-based volume requirements for procedures for all physicians
• Concurrent chart review of certain number of cases after age “x”
• Annual reappointment
• Concurrent proctoring of certain number of cases

Some Risk

• Require physician to have assistant at surgery or back-up immediately available
• Comprehensive physical and psychological evaluations

Do These Exams Yield Useful Information?

• If no baseline to compare to, what do results mean?
• Even if decline noted, at what level is it significant?
• BUT – exams can be viewed as flagging mechanism for focused review of practice and outcomes
High Risk

Automatic loss of privileges after a certain age.

Age Discrimination in Employment Act (ADEA)

- Applies to “employees” (though some courts are interpreting broadly)
- Who are over 40 years of age
- Applies to mandatory retirement, mandatory testing, etc.

BUT: Use of age is permitted if age is a “bona fide occupational qualification,” or “BFOQ”

E.g., airline pilots, bus drivers

Pilot’s deadly in-flight heart attack threatens to renew age debate
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Can an aging policy treat all physicians the same (e.g., internists and surgeons)?

If Age Is Used as a BFOQ
• Appropriate committee should review literature addressing:
  • Physical and mental effects of aging (e.g., pilot studies)
  • Relationship between age and patient outcomes
• Minutes should justify decision

Your biggest challenge!
“Man Legend”
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Senior members of the Medical Staff often:
• Are well respected
• Have mentored others
• Have served in leadership roles (including board)

Senior members of the Medical Staff often:
• Love what they do
• Have limited outside interests
• Are needed because of physician shortage
• Need to work

The Perfect Storm
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The Ultimate Balancing Act

• Protect patients
• Protect the practitioner
• Be fair to the practitioner
• Protect the organization
• Comply with accreditation standard
• Comply with Age Discrimination and Employment Act (ADEA)
• Comply with Americans with Disabilities Act (ADA)

Options

• Provision in Credentials Policy/Bylaws for “Practitioners Over Age ______”
• Late Career Practitioner Policy
• Peer Review Policy
• Practitioner Health Policy

Practitioner Health Policy

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Joint Commission
Standard MS 11.01.01

Hospitals must have a process to address:
• Education about impairment
• Self-referral and referral from others
• Confidentiality

Joint Commission
Standard MS 11.01.01

Hospitals must have a process to address:
• Evaluation of credibility of complaint
• Monitoring
• Reporting when practitioner is providing unsafe treatment
• Appropriate action

Process
• Education
• Reporting
• Fact-finding
• Meeting
• Evaluation
• Resolution
• Follow-up
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**Education**

Policy should address:
- Signs and symptoms of impairment
- Importance of reporting
- Downside of “enabling”

**Reporting**
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**Reporting**

Policy should:
- Emphasize confidentiality
- Describe process for reporting by others
- Encourage voluntary self-reporting

**Fact-Finding**

- Interview staff
- Review relevant documents
Wrong Question!
You don’t need “evidence” or “proof” to meet with a physician.

Meeting
Plan the Meeting with Care
• Don’t shoot from the hip
• Have a game plan (and an end plan)
• Review your documents
• Know your options
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Meeting

Plan the Meeting with Care
• Anticipate denial
• Emphasize confidentiality

Evaluation

• Practitioner Health Committee should select evaluating entity
• Evaluation is NOT quick visit with and evaluation by Dr. Elder
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Evaluation

• Dr. Elder should sign authorization permitting hospital and evaluating entity to communicate with one another and share information

Resolution

Conditions of reinstatement should be described in detail.

Follow-Up
Thank you.

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