Scrutiny at the Extremes: Addressing Competency and Credentialing Concerns in Early and Late Career Practitioners

Session Code: MN09

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Time: 12:45 p.m. - 2:15 p.m.

Total CE Credits: 1.5

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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Enumerate the increasing concerns raised by newly minted practitioners who join the medical staff out of training and best ways to resolve those concerns.
- Articulate the increasing concerns raised by “late career” practitioners and best practices to address those concerns.
- Describe policies and procedures that are being used widely to address the competency of older practitioners and review the related legal concerns.
- Review the various resources that exist to assist in the evaluation of competency concerns involving young or late career practitioners.
Credentialing Challenges Posed by “New” and “Young” Practitioners

“When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was astonished at how much the old man had learned in seven years.”

-- Mark Twain

Are concerns about newly trained physicians age bias or real?

- “Restrictions on residency training hours are producing doctors with inadequate experience.”
- “Today’s residents spend so much time on the computer they don’t learn ‘hands-on’ medicine.”
- “A newly minted surgeon knows how to do robotic surgery but can’t convert it to an open procedure when there’s a complication.”
Should FPPE for Initial Privileges Be Extended or More Intense for Newly Graduated Physicians?

• Is this permissible?
• Is this wise?
• What criteria should be used?

How Much Information Should Routinely Be Sought From Residency Programs When Privileging New Graduates?

• Should residency logs always be submitted?
• Should more than a director’s letter be requested as a reference?
• Should rotational evaluations be sought?
• Should questions about conduct be routinely and explicitly asked?

Are New Physicians Good Medical Staff Citizens?

• “All they care about is getting home as soon as possible. No work ethic!”
• “We can’t get any young physicians to show up at department meetings, general staff events, or volunteer for committees.”
• “Young doctors keep demanding technology – we did just fine without computers or a smartphone app telling us how to do things!”
Some Characteristics of Millennials

- Tech adept/tech reliant
- Like coaching, direction, feedback
- Want to work but do not want work to be their life
- Driven NOT by money, but by meaningful work and expect to “fly up” the corporate ladder sooner rather than later in their career
- Prone to change jobs once every few years in search of greater intellectual or creative challenge
- Team oriented and value collaboration and sharing of ideas

Some Characteristics of Millennials

- More comfortable & thrive in multicultural, diverse environments
- Prefer democratic, non-hierarchical workplace and may feel stifled by traditional, rigid workplace practices
- May not prefer:
  - Monday-Friday
  - Bias toward seniority/titles
  - Exclusion of junior employees from decision-making
  - Micromanagement
- Millennials tend to see themselves as customers, even in their employment relationships

Henry Ford Health System’s Recruitment and Engagement Strategies for Generation Y

- Gen-ERG-Y: a team created by the HFHS Diversity Council for employees born after 1980. Charge is to leverage multigenerational differences & commonalities for purpose of attracting & retaining talent. Gen-ERG-Y holds meetings, workshops, & events that focus on effective communication among the generations, collaborative work styles, etc.
- Generational Diversity Class: to help manage tension between the generations.
- HFHS Administrative Fellowship: an opportunity to provide intensive career development and coaching to millennial employees.
- HFHS Leadership Academy & HFHS University
Late-Career Physicians: A New Challenge for Healthcare Organizations and Medical Staffs

- You can always quit, so why quit now.
  Robert Kiyosaki

- The older I grow, the more I distrust the familiar doctrine that age brings wisdom.
  H.L. Menken

- I've finally reached the age where my Wild Oats have turned into All-Bran!
  Tom Wilson

Attitude of Some Young Physicians Toward “Old” Physicians

“Bad news, Dad—you’re brain-dead!”

A Growing Number of Physicians Are Working Into Their Seventh, Eighth, and Ninth Decades

Michael DeBakey – Performed surgery into his mid-90s
Why Are “Late-Career” Physicians A Concern?

- Demographic changes in the physician workforce
- A high percentage of doctors plan poorly for retirement and find it necessary to work longer than they would like
- A high percentage of late career physicians work part time and are thereby becoming low volume practitioners
- Evidence links quality of care and patient safety concerns to late career practitioners
- Colleagues often reluctant to challenge the quality of a long-standing member of their medical community, either because they don’t want to tarnish that individual’s reputation at the end of his career or because such persons may be influential and often are in positions of seniority.

Demographics of the Physician Workforce

- Approximately 1/3 of practicing physicians are 55 and older
- Approximately 40% of practicing physicians are 50 and older
- 25% are >65 and 40% of these are practicing
An Aging Physician Population

• AMA estimate of number of active physicians in 2020 by age:
  • > 65 years of age: 189,000 (18%)
  • > 55 years of age: 409,500 (39%)

A Growing Physician Shortage

• 20% of practicing physicians are planning to leave medicine in the next 5 years
• 36% of practicing physicians are planning to leave medicine in the next 10 years
• Projections suggest a shortage of as many as 100,000 physicians nationwide by 2020

Hospitals Under Increasing Pressure To “Cut Corners” When It Comes to Individual Physician Qualifications

Increasing Challenge of Physician Recruitment & Retention

versus

Maintenance of Demanding Standards for Competency & Quality
How Do High-Risk Fields Address Aging?

- Commercial airline pilots
  - FAA mandated medical exams
  - Mandatory retirement at 65
- FBI agents
  - Mandatory retirement is age 57
- Doctors
  - Mandatory CME
  - One third of physicians do not have a primary care doctor

Physical Changes with Age

- Decreased strength and endurance
- Decreased muscular flexibility
- Decreased range of motion
- Decreased postural steadiness
- Decreased grip strength
- Decreased nervous system responses
- Decreased visual capacity
- Decreased mental processing
- Decreased blood flow and tactile feedback

Connection Between Age & Competence

Increased incidence of illness and:
- Cognitive impairment (8,000 doctors based on prevalence data)
- Sensory impairment
- Medication side effects
- Mood disorders
- Substance use disorders
The Long Decline:

- Research suggests an inverse relationship between age and quality of performance.
- Over half the studies investigating age related performance of doctors find a very gradual decrease in clinical skill as one gets further from residency, with the decline accelerating after age 60.
- Additionally, state medical licensing board data show an increase in complaints and disciplinary actions for older physicians.

Background: Physicians with more experience are generally believed to have accumulated knowledge and skills during years in practice and therefore to deliver high-quality care. However, evidence suggests that there is an inverse relationship between the number of years that a physician has been in practice and the quality of care that the physician provides.
The Canadian Experience: Quebec

2001-2010: 1,618 physicians had an onsite visit to review their practice. As a result of the review they were classified as follows:

- Level 0: No action, received satisfactory evaluation
- Level 1: Recommendations
- Level 2: Recommendations and control visit follow-up
- Level 3: Refresher course or retraining or limitation mandatory (this action frequently resulted in the option of retirement)
- Level 4: Cancellation of licensure

Physicians over age 70 had 3x higher rate of cancellation (31%) compared to the group less than 70 years of age (10%). Age group 65-69 showed only a slightly higher rate of cancellation than those younger (13%) but they had nearly double the rate of Level 3 recommendations than those younger than age 65 (18% v. 10%).

The Canadian Experience: Ontario

- 22% of physician over 75 years of age had gross deficiencies in their practice
- 16% in the 50-74 age group had deficiencies
- 9% of physicians under age 49 had deficiencies

(Journal of Medical Regulation, Vol. 99, No. 1: 10-18, 2013)

There is evidence to suggest that older physicians are less adaptable to rapid change in medicine and technology.
Who to Protect and How:

- There is a hesitancy among medical staffs to confront the issue of declining performance with age from a “there but for the Grace of God goes I” idea of not betraying a colleague who has been a good doctor and part of the medical community for years.
- Published articles on the aging physician contain numerous examples of colleagues quietly correcting the orders of elderly physicians to prevent mistakes.

Who to Protect and How:

- Compensating for the physician’s decline are common actions taken by concerned colleagues and other members of the medical staff.
- This kindness can backfire, subjecting patients to potentially disastrous consequences, and the physician to an ignoble end to a fine career through malpractice actions or the loss of a medical license.

Physician’s Self Assessment

Meta analysis of physician self-assessment studies:

“A number of studies found the worst accuracy in self-assessment among physicians who were the least skilled and those who were the most confident. These results are consistent with those found in other professions.”

Meta analysis conclusion:

“... the preponderance of evidence suggests that physicians have a limited ability to accurately self-assess. The processes currently used to undertake professional development and evaluate competence may need to focus more on external assessment.”

- Davis, et. al. JAMA 2006: 296(9)
Traditional Approaches to Competency Assessment of Older Practitioners

- Almost none for outpatient practitioners
- Medical staff peer review for those holding medical staff privileges
- Focused assessments after poor care discovered: ordered by medical staff or a licensing body
- No proactive competency assessments unless attempting to return to practice and reactivate a license. Most people are surprised to learn that medicine is not regulated to protect the public from aging practitioners. This is unlike other industries (e.g. pilots) or practice in some other countries (e.g. mandatory retirement ages for surgeons).

How Are Healthcare Organizations Responding to a Growing Number of Late Career Doctors?

- Most are doing nothing
- Some medical staffs are adopting credentialing policies on “aging” physicians and making bylaws changes to accommodate these policies
- Licensing boards are requiring competency assessments when older doctors try to reactivate a license
- Specialty societies are relying on MOC, although this has become a flashpoint of opposition from older doctors.

Polling Question:

- Does your medical staff or hospital have a policy regarding aging or late career practitioners?
  - Yes
  - No
  - Are considering adopting a policy
The AMA Recommends Screening

An AMA task force has been meeting to develop guidelines.

Physician Age & Outcomes in Elderly Patients in Hospital in the US

*BMJ* 2017;357 (published 5/16/2017)

Patients treated by older physicians had higher mortality than patients cared for by younger physicians, except for those physicians treating high volumes of patients.

Systemic Review: The Relationship Between Clinical Experience and Quality of Care


Older physicians have decreased clinical knowledge, adhere less often to standards of appropriate treatment, and perform worse on measures of quality with respect to diagnosis, screening, and preventive care.
Case Scenario

Dr. Jasmine Joiner has been a fixture on the medical staff for more than 40 years. As a solo internist, she has provided service to the hospital and unassigned patients without complaint or request for additional compensation. She has outlived her husband, her four adult children are successful in the community, she is on multiple community boards or associations and she has held most of the leadership positions on the medical staff over the course of her career.

Now in her seventh decade, her practice is declining. She visits her office daily and attends very few inpatients. She is no longer on the ED call schedule as the result of the implementation of a hospitalist program that is now in its 10th year of successful implementation.

Case Scenario (continued)

Dr. Joiner’s patient care statistics are as follows:
- 2014 admissions: 4
- ALOS: 6
- Complications: 0
- Readmits within 30d: 1
- No patient complaints/no staff complaints
- No incident reports
- No peer review issues/No mortalities/No documentation issues

Dr. Joiner’s reappointment is fast approaching. She has full critical care core privileges, including critical care. She has indicated that medicine is her life-long calling, her father practiced until he was 90, she expects to practice another 10 years or so. She has reapplied for appointment and full privileges.

Dr. Joiner’s application has come before the Credentials Committee. How should it proceed?

Polling Question:
Pick the option below that best indicates how you would address the situation of Dr. Joiner:

1. Follow the medical staff policy on late career physicians (if there is one)
2. Require Dr. Joiner undergo a “fitness for work” exam
3. Recommend renewal of Dr. Joiner’s privileges in the absence of any evidence of poor performance
4. Ask the medicine department to make ICU privileges special privileges outside the core before taking action on Dr. Joiner’s reappointment
5. Options 1 and 4
2015 AMA Report:
Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians

“Physicians must develop guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.”

“Formal guidelines on the timing and content of testing of competence may be appropriate and head off a call for mandatory retirement ages or imposition of guidelines by others.”

Policies on Evaluation of Aging Physicians?

• What age threshold should you utilize?
• Is this legal? What about the ADEA?
• What should a policy cover?

What Do “Aging” Credentials Policies Typically Include?

• A target age for implementation – most typical choice is age 70.
  Some policies have a mandatory retirement age.
• Reappointment criteria that include a cognitive screen and a “fitness for work” physical exam
• Some policies provide for annual assessments after a certain age – both health assessments and FPPE
• Reiterate the MEC’s authority to request functional assessments and health evaluations
• Some employed physician groups (especially hospital owned) have adopted such policies under their personnel requirements
When is a Formal Independent Medical Exam (IME) Warranted?
What about a Functional Exam?

• Routine on all older doctors who raise competency concerns?

Where/By Whom Should Screening or Assessment of Late Career/Senior Physicians Be Performed?

Home institution or practice:
Advantages: Convenience/cost/control of process
Disadvantages: Potential bias/availability of resources/confidentiality concerns

Regional center:
Advantages: Relative convenience/Standardized eval.
Disadvantages: Cost/loss of control over process

National program:
Advantages: Standardization/experience/reputation
Disadvantages: Cost/geographic inconvenience/Loss of control over process

Benefits of Assessment

• Early identification of issues may enhance the physician’s ability to practice longer
• Renewed sense of confidence for practitioner and colleagues
• Identification of issues that are easily remedied
• Recognition of other professional opportunities
• Provide physician with information with which to evaluate options and make decisions
Who Should Pay for Assessments of Late Career Physicians?

- Hospital?
- Medical staff?
- The late career physician?

Legal Concerns Regarding Interventions with Older Practitioners

- Federal Age Discrimination in Employment Act (ADEA) – applies to companies with more than 20 employees and applies to those over 40.
- State laws anti-discrimination laws may apply. For example, the Pennsylvania Human Relations Act prohibits employment practices that discriminate on the basis of age. The law protects independent contractors, employees, and job applicants who are 40 years of age or older. Applies to companies with more than 4 employees.

Consider Practice Accommodations for Late Career Practitioners

- Decreasing hours/caseloads
- Allocation of more time with patients (e.g., scheduling adjustments)
- Accommodations based on findings (e.g., amplified stethoscope)
- Ongoing education with respect to electronic health records documentation
- Ongoing education to maintain fund of knowledge and awareness of current standards of care/competencies
- Decrease or limitation in scope of practice
Most Important: Start the Discussion
The Rapid Aging of America’s Practicing Physician Needs Should Be A Wake-Up Call To Action