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What Can Peer Review Do for You?

CASE 7: AGING PHYSICIANS: ENSURING CLINICAL COMPETENCE

WHAT:

Have any of these happened in your hospital lately?

- A late-career primary care physician still wants to manage ICU patients but fails to utilize the resources of critical care physicians and underestimates the severity of his patient's illness — and an avoidable poor outcome follows.
- An older urologist with waning dexterity perforates a patient's bladder during a routine cystoscopy.
- A general surgeon with a pristine 40-year track record nicks a patient's common bile duct in 50% of his most recent laparoscopic cholecystectomies.

As concerns about patient safety grow, are your medical staff leaders struggling with the painful question of what to do with valued, even beloved physicians whose signs of decline can no longer be ignored?

THE PROBLEM:

Physicians' competence is not supposed to add to patients' risks, but we all know it happens. Nearly one quarter of doctors in the United States are now over the age of 65. While some retain most or all of their abilities and skills, others experience profound impairments in cognitive skills, visuospatial abilities, and manual dexterity. Research shows that between the ages of 40 and 75, physicians' mean cognitive ability declines by 20%.[1]

The medical profession has long trusted doctors to self-evaluate their capabilities and voluntarily choose when to retire or scale back their practices. But as we see too often, physicians may fail to recognize their declining performance or refuse to step aside. There is no mandatory retirement age for doctors, and only 5 – 10% of hospitals have instituted policies to screen older physicians as of 2017.[2] In the absence of a national standard, hospitals are currently on their own to identify and remedy situations where a physician's age-related decline may place patients at risk. The majority of institutions have not even begun to face this issue with a coherent plan for assessment and remediation.

Experts working on the issue of how to best manage decline in aging physicians generally favor the development of screening programs rather than a mandatory retirement age for several reasons. a) There is great variability among individuals, with some providers retaining virtually all their skills and capacities, and others showing various types and degrees of decline; b) There is already a shortage of physicians, and compounding the physician shortage could outweigh the intended benefits.

Age-based screening does raise some legal questions, and a full discussion of this topic is beyond the scope of what can be addressed here. But as the problem has been gaining attention in recent years, fundamental points are becoming clear. When considering their options, medical staff leaders should be aware of some key facts.

ARE AGE-RELATED SCREENING POLICIES PROHIBITED? DO THEY VIOLATE AGE DISCRIMINATION LAWS?:

No. This is a common misconception among physicians and administrators alike. Many medical staff leaders have assumed that testing would be illegal, but this is simply not true. Screening of older physicians to ensure clinical competence has been ruled permissible for a number of reasons.

1. Public safety. The Age Discrimination and Employment Act (and corresponding state laws) prohibit the consideration of age in employment

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decisions such as hiring and firing. But mandatory retirement ages and age-based screening policies have been deemed legal in certain occupations because they directly impact public safety. Commercial pilots in the U.S. are required to retire at age 65, and beginning at age 40, they must undergo physical exams every six months to ensure they are fit to perform as pilots in command. Most air traffic controllers must retire at age 56, and federal law enforcement and firefighters must retire at age 57. Lawyers, judges, and certain other professionals are also subject to evaluations to ensure their judgment and cognitive abilities remain intact.

2. Courts have determined that screening programs to ensure clinical competence do not violate employment discrimination or disability laws.

   Most hospital-based physicians are not employees, but, rather, are members of a democratically governed, independent medical staff. In this model, physicians must apply for privileges to continue to practice, and healthcare facilities have broad latitude in ensuring their physicians maintain current competency. Employment discrimination laws are generally not applicable to independently credentialed physicians. Even when physicians are employees, courts have still upheld the use of individualized monitoring and testing. Moreover, laws related to disabilities (the Americans with Disability Act and corresponding laws) have been found to support the use of individualized assessments as a way to fairly review physicians' competence. In short, age-based screening by a health care facility to ensure competency is permitted and has been upheld in courts of law.[3]

STATUS 2018: A WORK IN PROGRESS

State and national organizations continue to develop and debate possible statutes and guidelines that might help facilities manage patient safety risks associated with aging physicians.[4] But until federal or state guidelines take on the responsibility, hospital medical staff leaders will be on the front lines of ensuring the competency of their late-career physicians.

WE ARE CONCERNED ABOUT A PHYSICIAN'S PERFORMANCE - WHAT CAN WE DO?

Med staff leaders are advised to take concrete steps to raise the bar for both quality of care and professional standards. Ideally, there should be protocols in place to identify and manage physicians who may be impaired for any reason, including physicians of all ages whose performance may pose a risk to patients.

1. Make full use of the OPPE and FPPE processes to identify and remediate physicians with poor or marginal performance. When performed consistently, ongoing professional practice evaluations will alert med staff leaders of emerging problems such as high complication rates or excessive surgical times. If a problem is identified, a focused evaluation can then be initiated.

2. Develop an aging physician policy to assess for potential declines in cognitive and physical skills that may affect clinical competence. External testing services have been shown to be better than internally managed screening.

3. Integrate both OPPE and FPPE data along with competence testing into the credentialing process, with physical and or cognitive testing included at the discretion of the medical executive committee.

4. Use the unbiased input from external peer review as part of the hospital's routine oversight process of every physician.

MDReview provides external peer review in every medical and surgical specialty as well as on-site consulting services when needed. Please give us a call to discuss any peer review related situation or concern.

References:

1. The Aging Physician and the Medical Profession: A Review. Dellinger, Pelligrini, and Gallagher. JAMA Surg 2017 Oct 1;152(10):967-971.
2. Geriatric Forensic Psychiatry. Jacob Holder and James Ellison, 2017. Chapter 37, The Aging Physician.
3. Legal Issues and the Aging Physician. Jeffrey Chase- Lubitz, Rhode Island Medical Journal, September 2017. www.rimed.org.
4. American Medical Association: Nuanced Approach Needed to Assure Senor Physician Competency, Oct. 16, 2016. https://wire.ama-assn.org/life-career/nuanced-approach-needed-assure-senior-physician-competency
5. American Medical Association: Competency and Retirement: Evaluating the Senior Physician. June 23, 2015. https://wire.ama-assn.org/ama-news/competency-and-retirement-evaluating-senior-physician
6. Age-based Testing of Physician Competence Stirs Controversy. Medscape coverage of the American Association of Geriatric Psychiatry, 2017. Nancy Melville, April 4, 2017. https://www.medscape.com/viewarticle/878168#vp_1
7. Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory? 28 Health Matrix: Law-Medicine J. (March 2018, Forthcoming) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2954834

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