

Patient Safety Tip of the Week

May 28, 2019 The Older Physician

In our July 7, 2015 Patient Safety Tip of the Week [“Medical Staff Risk Issues”](#) one of the issues we discussed was **“the aging physician”**. This is often even more difficult a problem to deal with than the disruptive physician. This physician is usually a very well liked and respected physician who has practiced at the hospital and community for many years. But now his/her skill levels and perhaps cognitive capabilities have begun to decline. But he/she may not be aware of this decline and everyone is afraid to confront him/her about it. Most of his/her patients still love him/her and the board members are his/her friends or have long interacted with him/her in community activities.

In a few cases he/she wants to continue practicing because they need the income. More commonly they want to continue practicing because they love what they are doing and that is their whole life. They feel obligated to their patients and communities. Some don't have outside interests and would not know how to exist without coming to the hospital.

In the “old days” these physicians would hang out in the medical staff lounge and be asked to serve as “assistant surgeons” (they didn't have to actually be surgeons) on surgical cases. But third party payors have now largely eliminated fees for assistant surgeons in all but a few select surgical procedures. So that route for staying active in the hospital has disappeared.

You begin to hear whispers amongst staff about their concerns regarding this physician. They all know that sooner or later he/she is going to do something that might result in patient harm. But they are not willing to come forward with specific examples. Medical directors and medical executive committees are often handcuffed when no one is willing to formally come forward with negative information on such physicians.

There is a good chance your hospital bylaws have not included any verbiage about physician age since they don't want to appear discriminatory. And it is extremely difficult to specify an age at which some sort of mandatory evaluation should be done. There are many physicians well in their 70's who practice just fine and some in their 50's whose skills have already deteriorated.

But there has been a lot of attention in the literature recently addressing the issue of the aging physician. The aging surgeon has probably received the most attention. For general surgeons, 46.4% are over the age of 55 ([AAMC 2019](#)). And the percentage over age 55 is greater than 50% for orthopedic, thoracic, urologic, and plastic surgeons. And

surgeons in rural areas tend to be even older. So the problem is not only identifying who can perform safely but there is also a manpower issue to be dealt with in the future.

Complicating the issue are a couple recent studies on patient outcomes of older physicians. Tsugawa and colleagues ([Tsugawa 2017](#)), analyzing a sample of Medicare patients age 65 and older cared for by hospitalists, found that, within the same hospital, patients treated by older physicians had higher mortality than patients cared for by younger physicians, except those physicians treating high volumes of patients.

But for surgeons, the same researchers ([Tsugawa 2018](#)) found that patients treated by older surgeons actually had lower mortality than patients treated by younger surgeons. There was no evidence that operative mortality differed between male and female surgeons. And, for eye surgeons performing cataract surgery, Campbell et al. ([Campbell 2019](#)) found that “late career” surgeons did not have more complications than eye surgeons earlier in their careers. That finding held up even when surgical volume was factored in.

So, age per se, cannot be the sole factor considered in decisions about the status of aging physicians. Katlic et al ([Katlic 2019](#)) note that “establishing a mandatory retirement age for surgeons would be a straightforward solution but would be illegal, inappropriate, and unfair because of the variability in function among older individuals of a given age”. There are a handful of occupations (eg. air traffic controllers) for which Congress has approved mandatory retirement age, but physicians are not one of them.

They note that some hospitals have adopted a Late Career Practitioner Policy in their medical staff bylaws. These hospitals may require physicians and advanced practice clinicians older than 70 years who apply for recredentialing to undergo physical examination, eye examination, and cognitive screening.

Katlic and Coleman previously described the elements of a formal Aging Surgeon Program ([Katlic 2014](#)). In both articles they described this as a more comprehensive option for surgeons identified either through screening or performance issues identified by medical staff. Their program is a 2-day, multidisciplinary, objective, and confidential evaluation of a surgeon's physical and cognitive function. It includes physical, neurologic, and ophthalmologic examinations, neuropsychological and physical/occupational therapy testing. A confidential report is then sent to the hospital medical staff that requested the evaluation. Based on the objective information provided in the report, the hospital medical staff may consider options such as continuing full privileges; no privileges; no operating privileges; operating privileges if assisted by another surgeon (routine vs only complex cases); assistant privileges only; focused review of cases (all vs certain number); or decreased work hours (eg, no on-call duties). Katlic et al do discuss surgical simulator testing but note that its validity for privileging issues has not yet been determined. (They also note that surgical simulator testing can be resource intensive, for both equipment and human time, and would need to be specialty specific.)

Weinacker ([Weinacker 2018](#)) described a Late Career Practitioner Policy that was implemented at Stanford Health Care (SHC). It uses focused physical exams and robust peer reviews to screen physicians. After turning 75, all physicians practicing at SHC must undergo physical exams and peer reviews every 2 years. She notes that age 75 was chosen somewhat arbitrarily, but the choice was guided by data that show the rate of decline of cognitive functions starts gradually as early as age 35 or 40 until about age 70 or 75, when deterioration begins to increase at a faster pace.

One issue we had not previously considered was the impact of employment status. As more and more healthcare organizations are employing physicians, they need to take into account the Age Discrimination in Employment Act. Weinacker notes that Act protects workers 40 years of age and older from being denied employment due to advancing age, but would not apply to physicians on staff who are not employed.

Because there were no data in the literature to support (or refute, for that matter) the use of cognitive screening to gauge a physician's ability to practice safely, Stanford Health Care dropped that requirement. Instead, they increased the number of peer reviews from 3 to 10, an approach that does have support in the literature. They ask the chief of surgery for names of 10 peers who are in a position to honestly and fairly judge a physician's ability to practice and include them in the peer review process.

Stanford Health Care does require physical exams. These can be performed by individuals' primary care physicians. The focus is on determining whether surgeons have the physical skills needed to perform the procedures for which they're privileged.

We have some concerns about who does the physical exam. We feel that having access to truly **independent evaluations** is **critical**. For one thing, the primary care physician may not fully understand the nature of the tasks performed by the individual physician being evaluated (especially when that physician is a surgeon). Second, physicians on your own hospital staff are often uncomfortable evaluating a medical staff colleague, knowing that their assessment may result in that physician losing privileges. Equally important in our litigious society is the threat of a lawsuit by a physician who might lose his/her privileges. We've seen instances where such physicians have sued for restraint of trade when a colleague in the same specialty has made an adverse determination about a physician. Because of that latter threat it is often impossible to get such an assessment within the same city or geographic region.

Importantly, Weinacker notes that the evaluations are **not** pass/fail assessments. Rather, they are used to determine whether modifications might be done to **help keep the physician in practice as long as possible**. For example, they may find a way to accommodate a surgeon who has a physical ailment that interferes with ability to operate. This **focus on maintaining respect** was likely one reason they were able to adopt their policy.

And respecting and valuing surgeons as they age is a main focus of timely new guidance and recommendations recently proposed by the Society of Surgical Chairs ([Rosengart](#)

[2019](#)). They note the need for **career transition discussions** with surgeons beginning early in surgeons' careers.

They note that there is great variability in the cognitive decline that takes place with aging, but also that clinical experience may offset declines in cognitive performance. As such, mandating retirement at a specific age would undoubtedly remove some competent surgeons from the workforce. But they also note that physicians' self-awareness of cognitive decline often does not coincide with objective performance measures.

Specific actions they recommend include:

- Begin discussions early in the career of faculty to establish plans for career transitioning as a senior surgeon. That should include financial planning to ensure financial stability as clinical compensation diminished later in career.
- The discussions should be private and confidential and exhibit respect for the surgeon's professional commitment.
- Promote non-clinical roles that might be taken as clinical activities are reduced (eg. in department or institutional administration, teaching, research, mentoring, coaching, peer review, community outreach, and development/philanthropy activities).

But the recommendations also include elements of performance assessment and privileges:

- Implement uniform cognitive and psychomotor testing beginning at least by 65 years of age, potentially as part of an ongoing professional practice evaluation.
- Consider change in clinical privileging from primary surgeon status to consultant or first assistant role and/or restrict cases to those of lesser acuity

In our July 7, 2015 Patient Safety Tip of the Week "[Medical Staff Risk Issues](#)" we noted the AMA had voted to approve a report saying it is time to have a system for assessing the competence of older physicians but there was considerable sentiment expressed that screening physicians at a certain age "is inappropriate and smacks of ageism" ([Frellick 2015](#)). The AMA had not yet developed criteria or processes for such assessments. Subsequently, guiding principles for assessing the competency of senior/late career physicians were proposed by the AMA's Council on Medical Education, but these were not adopted and the report was back to the Council on Medical Education ([Firth 2018](#)).

The American College of Surgeons did issue a Statement on the Aging Surgeon in 2016 ([ACS 2016](#)). While it was not in favor of a mandatory retirement age, it recommended that, starting at age 65 to 70, surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician for overall health assessment and regular interval reevaluation thereafter for those without identifiable issues on the index examination. It also encouraged surgeons to also voluntarily assess their neurocognitive function using confidential online tools. It also noted that voluntary self-disclosure of any concerning and validated findings is encouraged as part of a surgeon's obligations. It also noted that colleagues and staff must be able to bring forward and freely express legitimate concerns about a surgeon's performance and

apparent age-related decline to group practice, departmental and medical staff, or hospital leadership without fear of retribution. It stressed the importance of peer-reviewed methods, including ongoing professional practice evaluation, as part of recredentialing and, if a potential issue is identified, additional methods of evaluation may include chart reviews, peer review of clinical decision making, 360-degree reviews and patient feedback, observation or video review of operating room cases, and proctoring.

It acknowledged that there will be occasions where a surgeon will need to be referred to a comprehensive evaluation program, conducted at a number of specialized centers where a battery of tests for neurocognitive function can be conducted in the form of a neuropsychological assessment (the costs of which should be borne by the hospital or medical staff, not the surgeon). But it emphasized that these results cannot be used in isolation to determine continuation or withholding of hospital and surgical privilege but should be incorporated as an additional piece of information.

A 2017 review of the issue ([Dellinger 2017](#)) had recommendations for multiple stakeholders. In addition to calling upon healthcare organizations to develop policies for mandatory testing at certain ages and do more peer observation of actual care, specialty societies to provide standards and resources, local medical societies to provide resources to test solo practitioners or rural providers, individual physicians to voluntarily submit to annual exams similar to aviation physical that pilots must take, and liability insurance companies to offer lower fees to those physicians who submit to those exams.

And what if you're a patient? Family physician Jonathan Maltz, in a recent perspective in the Washington Post ([Maltz 2019](#)), had some good advice for patients to assess whether they should continue to be cared for by their aging physician. Be concerned if:

- A doctor you've known for many years doesn't remember you or frequently mixes you up with someone else.
- The physician is dismissive or impatient — and this is a change in his or her usual demeanor.
- When you ask your doctor a question, you often get a confusing or convoluted answer and asking follow-up questions doesn't help clarify the matter.
- The physician repeatedly forgets to do things (whether it's order tests, research a question or condition you have, refer you to a specialist, call you with test results or complete another task) that he or she promised to do.
- Your physician seems to refer you to another medical professional for nearly every ailment.
- Your doctor has difficulty hearing (or seeing) or seems to be a bit shaky handling instruments.

This issue of dealing with the aging physician is not going to go away. It's going to become more prevalent as our clinicians themselves deal with difficult issues about their careers. We hope healthcare organizations will develop a Late Career Practitioner Policy that focuses on patient safety but deals with the issue in a prospective, respectful and compassionate way. Recommendations such as those from the Society of Surgical Chairs

([Rosengart 2019](#)). and Stanford Health Care’s Late Career Practitioner Policy ([Weinacker 2018](#)) are a good starting point. The concept of beginning the discussion with your clinicians long before they are “aging” needs to be ingrained in your programs. Resources such as the [Aging Surgeon Program](#) at Sinai Hospital/LifeBridge Health (developed by Katlic and others) may be very helpful to you once have reached an age where their skills and cognitive functions may start to wane.

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LifeBridge Health. Aging Surgeon Program

<http://www.agingsurgeonprogram.com/AgingSurgeon/AgingSurgeon.aspx>



<http://www.patientsafetysolutions.com/>

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