



# Testing physicians based on age

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# Concerns About Senior Physicians

- ▶ Cognitive impairment: Screen by prospective testing
- ▶ Diminishing knowledge: Screen by recertification
- ▶ Slow to adopt new standards of care: Hard to systematically assess
- ▶ Often do excellent care of another decade: Fully capable people imprinted by their training. Hard to identify at credentialing or to associate with substandard results.

Beware of the young  
doctor and the old barber  
Benjamin Franklin



# AMA 2017 PHYSICIAN AGE DEMOGRAPHICS

- ▶ 300,752 physicians were 65 years or older in 2017, up from 241,641 in 2013
- ▶ 120,000 were "actively engaged in patient care," up from 97,000
- ▶ AMA Report Statement: "The literature is clear, an AMA report said, that cognitive and physical skills generally decline with age, and physicians are not excepted."

# Studies of Reporting to State Boards

- ▶ California 2004
  - ▶ Male, not certified, older, graduated outside USA
  - ▶ IM, FP, OB, Psych
- ▶ Oklahoma
  - ▶ Male, non-white, not certified, graduated outside USA
  - ▶ FP, Psych, OB, ER
  - ▶ Source of inquiry: 66% from public, 9% referrals by professionals
  - ▶ Most cited specific adverse events
- ▶ Ohio
  - ▶ Male, not certified, in practice under 20 years
  - ▶ Mostly substance abuse or drug offenses
  - ▶ Complaints of poor practice 7%

# Medicare Data

- ▶ Random 20% sampling of care by Hospitalists of hospitalized Medicare patients
- ▶ 2011-2014
- ▶ 30 Day Mortality
  - ▶ 10.8% doctors under 40
  - ▶ 11.1% doctors in 40s
  - ▶ 11.3% doctors in 50s
  - ▶ 12.1% doctors over 60
- ▶ Age related differences disappeared when patient volume exceeded 200 admissions a year

# Previous Studies on Older Physicians' Practices

- ▶ Decline in factual knowledge
- ▶ Less likely or slower to adopt newer standards of care
- ▶ Some evidence of worse outcomes in some aspects of care, inconclusive in others.

# Self-recognition of limitations

- ▶ Dunning-Kruger effect of overestimating ability is not age related
- ▶ Detecting decline from previous level of ability seems to be age related
- ▶ Some segments of cognitive decline are not noticed by self
- ▶ When noted by others, there is reluctance to report what seem minor lapses
- ▶ Objective measurement is less prone to rationalization or minimization



# Professional Organizations

- ▶ AMA Council of Education
  - ▶ Recommended developing guidelines for voluntary testing at age 70 in 2015
  - ▶ Voted down the guidelines that were developed: vote 282-222
  - ▶ A good idea may not be as good an idea when you do it.
- ▶ Society of Surgical Chairs
  - ▶ Recommended testing at age 65
  - ▶ Proposals include the dignified management and alternative use of remaining experience and skills for those surgeons who would need to reduce their practice determined by testing.

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# AMA Workgroup themes for Late Career Practitioner Policies

## Guiding Principles amended, sent to board, likely discussed in June

- Evidence-based
- Consistent with medical ethics
- Physicians are involved in development of standards
- Relevant to physician practice and required tasks in the physician's practice environment
- Motivated by ethical obligation for public health and patient safety
- Goal of assessment: to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment to allow the physician to continue to provide safe and effective care
- Protects right of physician to modify practice (unless public health or patient safety directly threatened)
- Transparent (to physicians and public)
- Education & Remediation: supportive of physician wellness, ongoing, proactive, no undue burden to physicians

"ON THREE THINGS DOES THE  
WORLD STAND: ON JUSTICE, ON  
TRUTH AND ON PEACE."

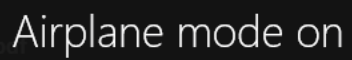
AS IT IS SAID "EXECUTE THE  
JUDGEMENT OF TRUTH AND  
PEACE IN YOUR GATES."

PIRKEI AVOT 1:18



# Ideal Policy

1. Clear on who must be assessed
2. How frequently
3. Who pays for the assessment
4. Physician consents to release of information to people who decide on privileges
5. Committee receiving the report may request additional information based on the report
6. Information confidential except to those specified to receive it
7. Potential adverse consequences of the evaluation understood in advance.



## Report back from the Board at the Annual meeting June 2019

No specific recommendations yet except as discussed.

AMA (and others) are hungry for more research on Late Career Physicians

Inspect

# MD SURVIVORS OF HIGH STAKE EXAMS

- ▶ IQ test: 2<sup>nd</sup> Grade
- ▶ Iowa Tests of Basic Skills: 5<sup>th</sup> Grade
- ▶ Drivers License Road Test: 10<sup>th</sup> Grade
- ▶ SATs: 11<sup>th</sup> Grade
- ▶ Organic Chemistry Tests: College Sophomore
- ▶ MCATs: College Junior
- ▶ National Boards: Medical School/Internship
- ▶ VDRL: Marriage
- ▶ Getting Fingerprinted: Licensure
- ▶ Specialty Certification Exam: Early Practice
- ▶ Recertification Exams: Ongoing
- ▶ Colonoscopy/Mammography: Adult Prime Years
- ▶ Neurocognitive Testing: Age 70 ?

# Screening Programs

- ▶ For Scripps and many other organizations, the plan is for screening to be done by PAPA, the University of California, San Diego's PACE Aging Physician Assessment program -- said to be the largest to provide this service in the nation.
- ▶ PACE is an acronym for Physician Assessment and Clinical Education
- ▶ Many other organizations perform various screenings in house, with or without cognitive computer tests, or are working on plans to contract with four other service providers.
- ▶ Some of the standardization of the process seems incomplete, particularly as individual institutions develop proprietary mechanisms.



# PACE Screening

- ▶ PACE is a multiple-day testing program which began 22 years ago to assess doctors referred by the Medical Board of California after negligence or behavioral issues threatened their license.
- ▶ Of the 1,000 physicians referred to PACE, an undisclosed number had age-related cognitive impairment that resulted in colleagues' concerns, but the physicians continued to practice because the complicated peer review process takes a long time, and doctors don't want to report on each other.
- ▶ Developed from a response to physicians of known impairment
- ▶ Being adapted to screening physicians without known impairment



# Microcog

- ▶ Most common neuropsychological screening format
- ▶ Developed 1993 as part of risk management initiative
- ▶ Owned by Pearson, which administers some of our certification exams
- ▶ Tests:
  - ▶ Attention/Mental Control
  - ▶ Memory
  - ▶ Reasoning/Calculation
  - ▶ Spatial Processing
  - ▶ Reaction time to visual and auditory stimuli
- ▶ Does not determine fitness to practice, only whether more formal, personalized testing is recommended

# Standardization of Microcog Scores

- ▶ Norms exist for each five year age interval
- ▶ Norms exist to adjust for educational level
- ▶ Scores for accuracy and for speed are determined independently
- ▶ Scores can be combined to a global score
- ▶ A neuropsychologist generates a report based on the data
- ▶ There are proprietary physician norms which Pearson still regards as a research tool
  - ▶ Pearson does not permit interviews with staff who are creating the physician norms as company policy

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## UT Senate Bill [217](#) (2018)

### Amended Utah Code

Bans cognitive screening by a:

- Health care facility (for employment, privileges, or reimbursement)
- Managed care organization, or
- DOPL for licensing (for-cause exempted)

Impact: Intermountain screened physician #97 before September 2018, then on hiatus

## UT House Bill [337](#) (2019)

### Rescinds the Ban

- Sponsored by: Rep. Dailey-Provost, Floor: Senator Hemmert
- UMA opposed, substitution negotiated
- Passed 28-0; 69-0
- Intermountain can resume screening.
- No impact on research registry.



The division may n

irements for licensure:

# Yale's Trial Balloon

- ▶ 141 clinicians screened
  - ▶ 81 no problems found
  - ▶ 34 additional screening performed
- ▶ 18 were deemed too incapacitated for unsupervised practice
  - ▶ 5 age 70-74, 4 age 75-79, 9 age over 80
  - ▶ All retired or agreed to supervised restrictions on practice
  - ▶ None had been reported as problems previously
- ▶ No sampling of younger physicians from Yale was taken but normative scores for different aged clinicians were part of the testing's development.
- ▶ Wonder how Yale would have handled a random sampling of their younger physicians, intended to be controls, who individually underperformed.
- ▶ Also don't know how active the impaired physicians were in clinical care, who did teaching, lab investigation, or administrative work that did not risk patient safety.

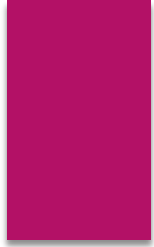


To prevent clinicians from preparing for it,  
Yale isn't releasing its test battery.

- ▶ Are the tests learnable? Can the test be beaten with familiarity?
- ▶ Would the clinicians that underperformed have the possibility of passing on retesting the initial screening once familiar with the tasks?
- ▶ The ability to learn might be retained
- ▶ Are the clinicians who passed but are retested with the next two year credentialing cycle at an advantage over those being tested the first time?

# How Reliable is the Testing Mechanism?

- ▶ "UC San Diego Health is in discussion on a potential policy, however, it hasn't established one because the science on the topic is unsettled."
- ▶ This got some angry responses from the psychologists that developed the testing though the validity of the testing programs and their predictability in removing unsafe physicians has not achieved unanimous consensus



"I have no doubt we're going to learn a lot over the next few years around how to do this right." James LaBelle, MD, chief medical officer for Scripps Health

# Legal Views

- ▶ Case by case assessment
  - ▶ Too often begins with an adverse event
  - ▶ Inconsistent means of identifying physicians of declining skills
  - ▶ Mandatory reporting, as for child abuse, not in place
  - ▶ Some risk in not reporting limited to adverse events happening
- ▶ Age based retirement
  - ▶ Advantage: non-judgmental from a legal standpoint
  - ▶ Disadvantages are many: loss of sometimes scarce skills from community, loss to the practitioner, risk of leaving parts of the public without care that they could have benefited from.
- ▶ Age based assessment
  - ▶ Non-judgmental: driven by age and not suspected lapses in performance
  - ▶ Policy supported by evidence correlating the process with valid assessment of ability to practice
  - ▶ Applied uniformly



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## Assessing Late Career Practitioners Adopted by Cppph Changes 6 10 151

[Original Document \(PDF\) »](#)

Contributed by Cheryl Clark (MedPage Today)

# Potential Litigation

- ▶ Title VII Civil Rights Act of 1964, mostly about race, national origin but sometimes applicable
- ▶ Age Discrimination in Employment Act of 1967
  - ▶ Age can be the identifier to assess ability to perform, but not the determinant of performance
- ▶ Americans with Disabilities Act of 1990
  - ▶ Must show that the disability affects performance or safety and cannot be reasonably accommodated.
- ▶ It is a lot easier for the lawyers if the medical organizations set clear standards on their own.

# Who Should Make the Protocol

- ▶ Physicians
- ▶ Employers
- ▶ Regulators
- ▶ Government

# \$MOOLAH\$

- ▶ PAPA testing program costs from \$1,100 to \$2,200, depending on how many doctors an institution sends for general initial screening.
- ▶ Individualized intensive screening for those flagged include evaluations by medical physician, neurologist, psychiatrist, psychologist. Estimated cost \$12-15,000.
- ▶ High cost places an incentive to screen only limited defined groups. Where problems are likely to emerge. Sometimes the physician or private group bears the cost. The price of the secondary screening itself induces some to retire rather than proceed if they are concerned about being screened out.
- ▶ More often the credentialling institution bears the cost, which can be considerable if, as at Yale, 30% need individualized testing of ability.
- ▶ There may be litigation costs, amount unknown.
- ▶ Actual return on an institution's investment or real costs in terms of eliminating large salaries through forced retirement or enhancements of safety remain unclear.

# Alternatives to Age Driven Testing

- ▶ Randomly test a sample in each decade of life weighted by age for cognitive function at time of recredentialing
- ▶ Mandatory reporting law for suspected incapacitated physicians similar to child reporting mandates
- ▶ Eventually there will be no physicians with permanent certification. Recertification mandates are an option, though at the risk of eliminating superspecialists who know all about islet cells but forgot which organ makes thyroid hormone.
- ▶ Make age a contributor to professional liability premiums. Malpractice losses for non-surgeons don't seem to support this
- ▶ Make recredentialing for everyone more rigorous
- ▶ Remove employer from process. Allow specialty societies to set standards and allow them to assess knowledge and ability to function within specialty.

# What we still need to know

- ▶ Stanford has been doing this since 2012, others since 2015
  - ▶ How many impaired practitioners were removed by this?
  - ▶ Was their investment in the process worth what they found?
  - ▶ Are these institutions any safer for patients because of this effort?
- ▶ Different institutions have used different screening mechanisms
  - ▶ Is there a means of comparing results among different protocols?
- ▶ "I have no doubt we're going to learn a lot over the next few years around how to do this right. " James LaBelle, MD, chief medical officer for Scripps Health
  - ▶ How will we know when we've done it right?

# BEST IF USED BY 70<sup>TH</sup> BIRTHDATE

Age > 70

