Evaluating senior physicians requires respect

By David Levine | November 15, 2016

The number of U.S. physicians older than 65 more than quadrupled between 1975 and 2013, and the issue of aging physicians continues to grow in importance. In 2015, the American Medical Association convened a panel to develop guidelines that will "help older physicians continue to provide high-quality care throughout their practice careers." Other risky professions, including aviation and the military, have mandatory retirement ages, but many in the medical profession resist similar safeguards against the decreases in physical and cognitive functioning we all face.

How can physician groups provide safe and effective care and keep a respectful but watchful eye on those whose skills may be diminishing? The medical staff at Stanford Health Care developed its own approach. athenaInsight asked Ann Weinacker, M.D., Stanford Health Care's vice chair of medicine for quality implementation, how her organization of some 2,000 physicians created its policy to screen older doctors.

Q Why did Stanford Health Care initiate its screening policy?

A We first started thinking about this in 2011, as the issue of aging physicians and the need to ensure competency was being discussed in various venues across the country. We felt that there would likely be mandates from regulatory agencies at some point addressing this issue, and we wanted to be sure that we were part of setting the standard in this regard. We wanted to be leaders instead of followers in this arena.

Q How was the policy drafted?

A We gathered a group of both older and younger physicians on our medical staff, including experts in neurology and cognitive impairment, psychiatry, and other subspecialties, to examine the issue and try to establish some kind of screening process that was robust and would be both evidence-based and legally defensible.

We looked at polices that had been developed by a few other groups as a starting point. The few existing policies typically had two components: a physical exam and a simple cognitive screen. We felt that peer review would be an important piece to this as well.

We worked closely with attorneys from our medical staff and our general counsel's office.

We took the draft policy to Stanford's Medical Executive Committee, which approved it by an almost unanimous vote, and it was implemented in 2012.

Q How was it received by physicians?

A Before the policy went into effect, I called each practitioner who would be affected to let them know about the policy and to explain the rationale. The vast majority told me they thought it was a good idea. There were a couple of practitioners who didn't — and, truthfully, a couple who really didn't — like the idea at all.

After the policy was implemented, a group of physicians who were opposed to the policy petitioned the Medical Executive Committee to revise the policy and to put it to a vote of the entire medical staff. I then commissioned a committee to address this and to again closely examine the literature. The result was to eliminate the cognitive screen and to make the peer review process much more robust, since robust peer review has considerably more support in the literature than does cognitive screening. The revised policy was then put to a vote and was approved.

Q How does it work?

A We require screening of all medical staff members every two years beginning at age 75. We included in the policy a provision that would allow us to invoke the policy whenever concerns regarding competency of a medical staff member are raised, regardless of age.

The screen is not a "pass-fail" test, and if concerns are raised during the screening process, we refer the practitioner for further evaluation.

Q If the screen is not "pass-fail," what is its intention?

A The intention is to identify physical or cognitive areas of concern that could interfere with a practitioner's ability to practice safely. Whenever possible, our goal is to identify challenges faced by the practitioner and to help mitigate those challenges or help the practitioner alter his or her practice if possible. Identifying challenges doesn't mean the practitioner has to retire or that we are suggesting retirement. Also, we allow physicians to appeal to the Medical Executive Committee if they think the findings of the screening are in error.

Q What advice would you offer to other physician groups that may be considering such a policy?

A Developing a policy like this is not for the faint of heart. It takes a lot of time and energy, and such policies are not uniformly popular. I would suggest first determining if there is interest and support in the institution for a late-career practitioner policy. It is then important to engage a representative group of stakeholders to be part of the process of developing a policy.

When we first talked about developing this policy, we wanted to do two things: Ensure the safety of our patients, and be respectful of our physician colleagues who might be challenged in some way by physical or cognitive impairment. We wanted to intervene early to address any impairment and help physicians adjust their practice or workload so they could continue to be productive. That was and is really important.

For those of us who have been practicing medicine for decades, medicine is not just our job —it's our life. The idea of being told we can no longer participate in this portion of our life is terrifying. It threatens the core of who we are. I think we have to be very careful to try and support each other in any way we can.

David Levine is a regular contributor to athenaInsight. This interview was edited and condensed.

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