CONCERNS FOR THE AGING PHYSICIAN: MYTH OR REALITY?

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“Most people don’t grow up. Most people age. They find parking spaces, honor their credit cards, get married, have children, and call that maturity.

What that is, is aging.”

*Maya Angelou*
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COUNTERTHINK

YES, I CAN TESTIFY THAT OUR ANTI-AGING PILLS DO WORK—A LITTLE TOO WELL, ACTUALLY.

DR. GRAY  DR. KATZ  DR. KNOW  DR. SAY

CONCEPT-MIKE ADAMS  ART-DAN BERGER  WWW.NATURALNEWS.COM

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Age-related changes in mental functioning vary considerably across individual and cognitive landscapes, with some cognitive functions appearing more susceptible than other to the effects of aging.

For some individuals, mental decline is not inevitable. A portion of older adults retain excellent cognitive function well into their 70’s or 80’s and perform as well or better than young adults.

Others, although within the normal range, show signs of decline by age 60.

Nonetheless, neuroscientists seem to agree that as one ages, one is prone to develop some mental and performance impairment.
The basic areas most affected by age are memory and attention. Neither are unitary functions, and evidence suggests that some aspects of attention and memory hold up well with age while others show significant decline.
This brief overview provides background into the evaluation and study of the practicing physician and how the aging process may serve to negatively impact the overall competence and performance of the physician in his/her medical practice.
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Old doctors never die
they just lose their patience.
Implications and Research: One statistic researchers appear to agree upon is that the number and proportion of older physicians still practicing in the U.S. is increasing.

The Association of American Colleges estimated that in 2012, more than 225,000, or 27.6% of physicians nationally were age 60 or older, and the trend would signal that such percentages have only increased in recent years.
An in-depth review of sixty-two published studies of physicians produced somewhat troubling findings: in more than one-half of those studies, declining clinical performance outcomes were correlated with increased age.


The studies’ authors concluded that there seems to be solid evidence that concerns can arise as the practitioner ages.
Any concern over the aging population of physicians and the potential effects of that aging may have on the individual physician’s overall clinical performance must be contrasted with the reality that there is a significant and growing shortage of physicians in the U.S.

- Recent study discloses that by the year 2020, the shortfall between the physicians we have and need will exceed 85,000.
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Hospital obligation – provide patients with safe and competent care

Courts have long held that hospitals have a duty to uphold the proper standard of care for their patients by selecting and retaining only competent physicians.

Such standards are often employed as a “sword” in malpractice lawsuits targeted at hospitals alleging negligent credentialing of a physician: the hospital *knew or should have known* of the medical staff physician’s lack of competence.
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Illustration of claim for negligent retention and credentialing:

Patient treated by 75-year old thoracic surgeon, who suffers a bad outcome. Malpractice suit ensues.
Federal laws and regulations, and in particular, *Medicare Conditions of Participation*, place a heavy burden upon both the medical staff and the hospital governing board to appropriately and adequately credential physicians.

Additionally, credentialing organizations have each set forth lists of responsibilities upon medical staffs and hospitals to appropriately credential and grant privileges to the physician to practice.
The Issue of Physician Competence

Federation of State Medical Boards Special Committee of *Evaluation of Quality of Care and Maintenance of Competence* defines “competence” as,

‘possessing the requisite abilities and qualities to perform effectively in the scope of professional practice’

In contract, *dis-competence* is defined as a failure to maintain acceptable standards in one or more areas of professional practice.
One such source of *dis-competence* is **impairment** – the inability of a physician to practice with reasonable skill and safety by virtue of a mental or physical illness, or abuse of a controlled substance, alcohol or other substances that impair ability.

Physical illness can occur to anyone at any age, and the physician is not spared from these events. And, as with the general population, the cumulative proportion of the population to suffer from one of the many sources of physical illness increases as one ages.
The undeniable fact from studies on aging in general, and aging physicians in particular, is unequivocal regarding the correlation of age and competence.

Studies report a statistically reliable negative correlation between age and competence.

Available data indicates that the current population of older physicians perform less well on re-licensure exams.

On the other hand, an equally prominent counter—finding of medical outcome quality studies is a positive relationship between experience, number of procedures performed, and most measures of quality.
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Interim Conclusion – there are no simple answers to the concerns for the aging physician, but statistics urge that serious consideration be given to this potentially troubling conundrum.

And, proactive planning through hospital and medical staff rules and policies should be established and implemented to address these inevitable issues.
Paving the Road towards Solutions

One possible solution to the conundrum lies with hospital medical staff bylaws, which could be redrafted or revised to address the issues raised with the aging physician.

Caution! It could be a difficult task, both politically and emotionally inasmuch as it is fair to assume that many of these aging, or “senior” physicians serve as mentors or senior spokespersons on the medical staff, and are often deservedly well-respected.
CONcerns for the aging physician: myth or reality
On the other hand, it is a well-accepted principle that the ultimate **objective** must lie with the welfare of the patients served.

A senior physician exhibiting many of the expected signs of aging could well jeopardize the fulfillment of that **objective**.

Not to mention the hospital and medical staff liability exposures that may well arise from negligent retention and credentialing.
Paving the Road towards Solutions

The Medical Staff may already have at its disposal a procedure such that if it knows or strongly believes that there is evidence that the senior physician is displaying, for example, tremors, forgetfulness, or perhaps dispensing wrong medications.

Another tool would be to have in place a credentialing standard or policy for senior physicians such as requiring all physicians to undergo an evaluation assessing competence once they reach, for example, age 65.
Benefit of Utilizing Wellness Committee

Offers opportunity to identify issues that may (or may not) be obvious to many colleagues, and enable thoughtful recommendations to be made and plans developed if the senior physician’s competency is a concern.
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Cautionary Downside

There are risks to taking such measures which target senior physicians. Besides the obvious potential for age discrimination claims based upon the ADA or Section 504 of the Rehabilitation Act, such contemplated staff bylaws and policies may be crafted as to have the opposite effect of singling out the questionably (‘borderline’) competent/aging physician; i.e., be overly inclusive.
Cautionary Downside

Overall, a hospital’s peer review process may simply not be designed to be sensitive enough to filter through the issues and thereupon identify potential problems.

However, if a hospital has a robust peer review process, it might not be entirely necessary to create policies that in effect, ‘draw the line’, thereby requiring testing measures for those physicians reaching or surpassing a particular age.
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It is essential that together, the medical staff and hospital administration commit to improving its practitioner health and wellness policies with regard to physicians who do have some sort of impairment or clinical competence concerns.

Urge prompt and timely recognition and intervention.

It is equally important to remind and educate the medical and hospital staff on signs enabling recognition of physical impairment or competency issues and encourage individuals to bring them forward for the good of the hospital, medical staff, the effected physician, and above all, patient care, without fear of recourse or reprisal.
Perhaps a byproduct of strengthening existing traditional policies and procedures will be the reduction or elimination of a need to develop a program with its criteria specifically targeted at the aging, or senior physician.

Such could, to a large degree, prevent the circumstances which might otherwise create dissention, polarization and inner staff turmoil with concerns, justifiably or not, of a hospital administration or medical staff allegedly targeting or disfavoring the aging staff physician.