The Aging Physician:
Practical Solutions for a Sensitive Issue

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“Normal” changes associated with aging

- Atrophy of brain
- Decline in number of brain neurons
- Benign senescent forgetfulness
- Decreased lean muscle mass
- Decreased visual acuity
- Diminished hearing
- Decreased reflex time
- Osteoporosis
- Arteriosclerosis
- Decreased compliance of arteries and left ventricle
Mild cognitive impairment

- Numerous international population-based studies
- Prevalence between 15% and 20% in persons 60 years and older
  - Mayo study of patients over 70 is 16%.
- The annual rate in which MCI progresses to dementia varies between 8% and 15% per year,
- However, not all MCI is due to Alzheimer disease, and identifying subtypes is important for possible treatment and counseling. If treatable causes are identified, the person with MCI might improve.
• Assessing the Performance of Aging Surgeons
  • Katlic et. al., JAMA 1/14/19
    • The increased experience of older surgeons warrants a critical evaluation to balance the strength of their experience with the potential of cognitive and functional decline inherent with advancing age.
    • The ACS currently recommends voluntary physical examination, eye examination, and online screening tests of cognition for surgeons between ages 65 and 70 years
• Cognitive Changes and Retirement among Senior Surgeons (CCRASS): Results from the CCRASS Study
    • Self-perceived cognitive changes play a role in decision to retire but are not related to objective measures of cognitive change, and are not reliable in the decision to retire.
Literature

• Physician age and outcomes in elderly patients in hospitals in the US: observational study
  • Tsugawa et. al. BMJ
    • 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

• Age and Operative Mortality
    • Medicare 460,00 patients undergoing procedures between 1998-1999
    • Pancreatectomy, CABG, carotid endarterectomy, esophagectomy, cystectomy, lung resection, aortic valve replacement and AAA repair
    • Mortality increased only in pancreatectomy, CABG and carotid surgery, in surgeons older than 60 who often had the lowest volume
Comment

- Setting an age-based standard for cessation of practice makes no scientific sense
- Humans age in a very heterogeneous way
- To the extent we can measure such things, aging brings experience, compassion, and wisdom
Risk Factors Other Than Aging That May Affect Clinical Competence

- Poor performance in medical school
- Solo practice
- Lack of hospital privileges
- Lack of ABMS board certification
- Out-of-scope practice
- Clinical volume
- New knowledge/procedural skills
- Fatigue/stress/burnout
- Health issues—mental and physical—may or may not relate to aging

Stephen H. Miller, MD, MPH Coalition for Physician Enhancement Meeting, November 10-11, 2011
Responsibility

96% of physician responders agreed that impaired or incompetent physicians should be reported to the appropriate authorities.

45% reported that they had encountered such colleagues and failed to report incompetent colleagues.


- Independent complete history and physical examination, to include screening vision and hearing
- Assessment of mental health using inexpensive standardized tools
- Cognitive assessment (Microcog or MOCA)
- Peer review (?)
- Goals would be safe patient care, quality improvement, maximizing physician health
- If needed, accommodations where possible; including “winding down,” transitioning to retirement
California Public Protection and Physician Health Inc. (CPPPH)

- Funded by CMA, CHA, specialty societies, county medical societies, and professional liability insurance carriers.
- Mission Statement: “…to develop a comprehensive statewide physician health program so that California does not remain one of the few states without such a resource.”
- Outreach: Regional Workshops on “Neuropsychological and Psychological Factors” and “Legal Aspects” relating to Aging Physicians
AMA – 2015 Report: Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians

- “Physicians must develop guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.

- Formal guidelines on the timing and content of testing of competence may be appropriate and may head off a call for mandatory retirement ages or imposition of guidelines by others.”
AMA Guiding Principles 2017

• Evidence-based
• Ethical
• Relevant
• Accountable
• Fair and equitable
• Transparent
• Supportive
• Cost conscious

• Interim meeting 2018 – not adopt – back to Council on Medical Education working with SPS
UC San Diego LCHS

• Review of self-report health questionnaires
• History and physical examination
• MicroCog™ Cognitive screening exam/MOCA®
• Mental health screen (PHQ-9, GAD-7)
• Substance use screen
• Dexterity test (for proceduralists only)
• Suturing simulation (for those that suture)
Final determinations

• NO FURTHER EVALUATION RECOMMENDED
  • Results either indicate that no presence of illness exists that interferes with the physician's ability to safely perform the duties of his or her job OR that presence of illness exists but currently does not interfere with the physician's ability to safely perform the duties of his or her job. Reevaluation may be recommended depending on the expected course of any present illness(es).

• FURTHER EVALUATION RECOMMENDED
  • Results indicate a possible impairment exists due to a physical or mental health problem. For those identified with possible impairment a fitness for duty evaluation may be recommended.
A Pilot Study of an Assessment Battery of Physical, Mental and Cognitive Screening Process for Senior Physicians

• Submitted for publication

• KEY POINTS

• Question: To determine the acceptability and feasibility of a screening assessment battery of physical and cognitive abilities for senior physicians.

• Findings: This descriptive study recruited 30 physicians assessing their health and cognitive abilities and their reaction to the screening battery. Eight of the thirty required/may require further cognitive evaluation. The screening assessment was judged a positive experience and that screening senior physicians is a good idea.

• Meaning: While needing further validating study, the battery for screening the health and cognition of senior physicians was acceptable and feasible.
## Active work: Total evaluations 62, 7 Contracts (7/19)

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State of Washington
Medical Quality Assurance Commission

- Age 30-55 screen every 7-10 years
- Age 55-65 screen every 5 years
- Age 65-75 screen every 2 years
- Age 75+ screen every year
Accommodations

• Can a surgeon with early mild cognitive impairment first-assist at surgery?
• What if something bad happened and that became generally known, even if it were not the surgeon’s fault?