



The American College of
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WOMEN'S HEALTH CARE PHYSICIANS

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Committee on Patient Safety and Quality Improvement

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Patient Safety and Quality Improvement in collaboration with Ilana Addis, MD, MPH.

The Late-Career Obstetrician–Gynecologist

ABSTRACT: The American Medical Association reported in 2015 that physicians 65 years and older currently represent 23% of the physicians in the United States. Unlike other professions such as commercial airline pilots, who by law must have regular health screenings starting at 40 years and must retire at 65 years, few health care institutions or systems have any policies regarding the late-career physician. Although there is an increase in accumulated wisdom and verbal knowledge with age, there is also an overall decline in recall memory, cognitive processing efficiency, and executive reasoning. The goal of physicians and health care institutions is to provide safe and competent care to their patients. Therefore, when considering the performance of a physician, the quality of care provided and safety of the patient are of the utmost importance. It is important to establish systems-based competency assessments to monitor and address physicians' health and the effect age has on performance and outcomes. Retention strategies can support areas of cognitive or technical decline while capitalizing on the aging doctor's strengths, and workplace adaptations should be adopted to help obstetrician–gynecologists transition and age well in their practice and throughout their careers.

Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations regarding the late-career obstetrician–gynecologist:

- It is important to establish systems-based competency assessments to monitor and address physicians' health and the effect age has on performance and outcomes.
- Workplace adaptations should be adopted to help obstetrician–gynecologists transition and age well in their practice and throughout their careers.
- To avoid the potential for legal challenges, hospitals should address the provisions of the Age Discrimination in Employment Act, making sure that assessments are equitably applied to all physicians, regardless of age.

Introduction

In 2015, the American Medical Association reported that physicians 65 years and older currently represented 23% of the physicians in the United States (1). The AMA also

reported that within this group, 39.3% were actively engaged in patient care (1). Unlike other professions such as commercial airline pilots, who by law must have regular health screenings starting at 40 years and must retire at 65 years, few health care institutions or systems have any policies regarding the late-career physician.

Normal aging is a series of time-dependent anatomical and physiological changes that are a combination of primary (intrinsic, programmed cell death) and secondary (extrinsic, wear and tear) factors. These may have a generalized effect on multiple functions as well as specific sensory changes, including vision, visual processing speed, and hearing (2). Additionally, although there is an increase in accumulated wisdom and verbal knowledge with age, there is also an overall decline in recall memory, cognitive processing efficiency, and executive reasoning (2, 3). The memory of healthy older adults is preserved for well-learned material, but the ability to process novel information declines, mainly in the area of executive function. This natural, progressive process ultimately can reduce physiologic reserve, decrease speed of information processing, lead to confusion or memory loss, and alter

psychomotor performance (3, 4). Decreased cognitive efficiency is seen, in particular, beyond 75 years of age (4, 5), with resulting confusion and memory loss being self-reported to interfere with daily life and work (3).

Among physicians, the physiologic changes can present as a decrease in efficiency and can affect response time and performance, potentially leading to job difficulties. These changes may result in adverse events because of issues with technical skills, cognitive processing and reasoning, planning, or attention (6). In a physician with cognitive impairment, one might see more prescription errors, irrational business decisions, and loss of skills, and there may be dissatisfied patients, patient injuries, and even lawsuits. In fact, a systematic review showed that in a majority of studies, measures of quality of care decreased with increasing physician's length in practice (7).

Understanding the aging process and its effect is especially important when addressing its effect within the physician community. It is essential to consider all factors in context and balance the important benefits of wisdom, knowledge, and experience that come with age. Data show that most surgeons reach performance peak at 45–50 years (8). Aging physicians may have decreased analytical ability and difficulty incorporating new knowledge, but they also may have better nonanalytical, experience-based decision-making skills (9).

Individual physicians suffering from cognitive impairment may be more likely to minimize their health problems, not take time off, poorly understand and distrust occupational health services, and self-diagnose and self-prescribe (6). Other physicians, family, colleagues, and institutions may consciously or unconsciously protect the physician at the expense of patient care.

It is important to establish systems-based competency assessments to monitor and address physicians' health and the effect age has on performance and outcomes. On an organizational level, there are opportunities, through aspects of the credentialing process as required by The Joint Commission, that can be applied to addressing practice concerns in the late-career obstetrician–gynecologist. The Joint Commission requires ongoing and focused professional practice evaluation of hospital medical staffs. The ongoing professional practice evaluation process is intended to allow a hospital to identify professional practice trends that affect quality of care and patient safety as they relate to privileges granted to a physician. The focused professional practice evaluation process, however, evaluates the privilege-specific competence of a physician. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance, usually occurring in a situation in which there is no documented evidence of competently performing the requested privilege, but also may be applied when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care. Although the ongoing professional practice evaluation and the focused pro-

fessional practice evaluation are tools to help identify competency and possible impairment, the tools would not necessarily recognize the slow decline of a late-career physician.

Medical and specialty organizations have released policy statements addressing aging and impaired physicians. The American Medical Association Council on Medical Education states: "Physicians should be allowed to remain in practice as long as patient safety is not endangered and that, if needed, remediation should be a supportive, ongoing and proactive process. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation. Therefore, physicians must develop guidelines/standards for monitoring and assessing both their own and their colleagues' competency" (1). The American College of Surgeons also has made a statement on this issue recommending that starting at 65 years to 70 years, surgeons voluntarily undergo confidential health assessments (10).

Considerations

Quality of Care

The goal of physicians and health care institutions is to provide safe and competent care to their patients. To this end, all clinically active physicians should maintain current credentials and privileges. Therefore, when considering the performance of a physician, the quality of care provided and safety of the patient are of the utmost importance. Any concern of colleagues, nursing staff, or administrators should be addressed through the appropriate pathway.

Competency Assessment

Development of a useful competency assessment to monitor performance is imperative to evaluate physicians at any age (11). Although competency assessment is frequently discussed in the literature, there has been no discussion of best methods (12). Limitations of assessment methods include lack of rigor of peer-review groups, reliance on self-identified problems, and the difficulty of approaching and reporting senior peers (13, 14).

Assessments could include any of the following:

- Evaluation of mental and physical health (including vision, hearing, and dexterity). Areas in which deterioration could occur over time include visual acuity, hearing, and cognitive ability.
- Review of demonstrated performance of clinical care
- Evaluation of surgical and clinical expertise. Sample guidelines for competency-based evaluation have been developed by California Public Protection and Physician Health, Inc., as well as the Association of American Medical Colleges.
- Participation in continuing medical education that results in documented learning and behavioral change

- Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation
- Maintenance of certification, if required
- External assessment and remedial education programs
- Periodic self-screening of cognition and mental and physical wellness using validated tools

Adaptations

Workplace adaptations should be adopted to help obstetrician–gynecologists transition and age well in their practice and throughout their careers. Physicians who are identified as aging well by their peers have adopted certain changes to maintain their practice (15–17). These include the following:

- Spending more time with patients
- Avoiding isolation in areas of unfamiliar practice
- Retiring from intense or new procedural activities
- Using memory strategies
- Minimizing night shifts or maintaining consistent hours
- Participating in fewer consecutive shifts
- Exchange of clinical duties for teaching and administration

Retirement Planning

Planning for retirement should start early in one’s medical career. Physicians have a unique combination of assets and liabilities. With an intense schedule, a lack of diversified activities, and more attention on present-day duties, there may be a lack of long-term planning for retirement. Emphasizing not just on the financial aspects of retirement planning, but also the changes in habits, activities, and focus that occurs with retirement is an important step in assisting the aging physician in the transition out of active clinical practice and maintaining a rewarding contribution in the workplace.

Retirement Policies

A policy of mandatory retirement is inconsistent with supporting workforce participation among aging people. Mandatory retirement does not fit well with the current understanding of cognitive aging, which is highly variable in onset and severity (18). Indeed, it would lead to a lost opportunity for junior practitioners to benefit from the clinical experience and knowledge of longtime health care providers. Additionally, workforce issues in obstetrics and gynecology, and in medicine as a whole, make mandatory retirement untenable. Mandating retirement would eliminate some of our most learned and experienced health care providers, many of whom are still providing high-quality care, from the care team at a time when our overall population is aging and requires more care.

It is likely, however, that there is a competency-based ceiling that may be related to age and may vary among different medical specialties, as well as among individuals. Arguments for a set retirement age include the loss of insight, which often accompanies cognitive decline and the reluctance of physicians to relinquish their medical identity (19). Hospitals may wish to consider assessing the physical fitness of all physicians, regardless of age, on a regular basis to ensure they are physically and mentally capable of performing their duties. Much of this decision making in how to address aging physicians has been and will be left to the credentials and medical executive committees of individual institutions, hospitals, and health care systems and should be reflected in the institutional governing bylaws and documents. To avoid the potential for legal challenges, hospitals should address the provisions of the Age Discrimination in Employment Act, making sure that assessments are equitably applied to all physicians, regardless of age.

Transitional Phase

Encouraging “transitional phase” activities may maximize the contributions of the aging physician. Retention strategies can support areas of cognitive or technical decline and capitalize on the aging doctor’s strengths. These can include the following:

- Transition from high-acuity care to routine ambulatory care
- Transition away from major gynecologic and obstetric surgical procedures
- Participation in medical education at any level and cross-disciplinary teaching
- Serving as a mentor or preceptor
- Participation in research
- Transition to leadership and administrative work
- Performing volunteer work
- Assisting in medicolegal work

Conclusions

According to the American Medical Association, the nation’s population of physicians is aging, with 23% older than 65 years. Research shows that as physicians age there is an increase in cognitive decline and with that a decrease in quality of care. However, there is no universal screening process in place for the aging physician. The American College of Obstetricians and Gynecologists recommends that when evaluating an aging physician, focus be placed on the physician’s quality of care provided to patients. Although it is imperative to develop useful competency assessments to monitor performance, a policy of mandatory retirement based solely on age goes against supporting workforce participation among aging people and could deprive patients of health and care and waste an opportunity to pass years of experience

on to younger physicians. Methods should be developed for physicians to age well in practice. This could include limiting call shifts, avoiding isolation in new settings, and retiring from intense or new procedural work. With this in mind, methods of transitioning an older physician into different roles that are acceptable to the physician should be developed while ensuring and maintaining excellent quality of care for patients.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-info/LateCareerObGyn.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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