More hospitals screen aging surgeons to make sure their skills are still sharp

Surgeon Dr. Herbert Dardik wanted to return to the operating room at Englewood (N.J.) Hospital and Medical Center soon after recuperating from bouts of serious bladder and heart conditions in 2015. But officials at the facility balked. While the 79-year-old chief of general and vascular surgery performed just a few complex operations each week, his age and recent health episodes made hospital administrators apprehensive about a prompt return.

They had few tools at their disposal, though. Hospital policy limited interventions to clinicians who had made medical mistakes. Dardik had never had an adverse event with a patient under his care.

Surgical chief Dr. Michael Harris offered an alternative. He asked Dardik to try a program in Maryland that provides cognitive and physical examinations for aging surgeons. “I reacted not only negatively, but even with hostility,” recalled Dardik, who still swims laps daily in his pool. In fact, he challenged Harris to a swim-off. “I kept thinking, 'Who knows better about my capabilities than me? ’”

Harris insisted. “We want to make sure our clinicians are operating at the top of their game,” he said. “That means that sometimes we need to intervene.”

It’s never easy to initiate conversations about age-related physical and cognitive changes among surgeons, whose slightest slip-up can cause irreparable harm to patients. The aging process affects each person differently. And while some acknowledge the changes that come with getting older, others may deny them.

These difficult conversations have become more commonplace in recent years, because physicians—like everyone else—are living longer. Advances in medicine, personal wellness and public health, along with the desire to preserve a sense of purpose and their lifelong identity, have led many to work well beyond traditional retirement age.

As a result, a growing number of health systems are creating policies that require clinicians of a certain age to undergo physical, cognitive and clinical testing. Those programs have been met with ire by career practitioners, who argue that age is just a number. Doctors—no matter what their age—already must renew their medical licenses at regular intervals with state medical boards.

But medical groups, patient safety leaders and others counter that the renewal process does not look for age-related cognitive and physical decline that could harm the quality of care provided to patients. “The medical profession should act now, lest others dictate the direction of this important issue,” concluded a 2013 report that summarized opinions of medical, legal and public policy experts.

“Medical boards need to have policies for dealing with this, just like they should have policies for dealing with doctors who are not competent or who harm people repeatedly,” said Lisa McGiffert, director of the Safe Patient Project for Consumers Union.

The 1967 Age Discrimination in Employment Act gives the U.S. labor secretary the power to ensure that aging workers are not displaced from jobs as a result of arbitrary age limits. The law did exempt some high-risk
industries.

Air traffic controllers, for instance, must retire at age 56. Federal firefighters bow out at 57. Airline pilots must retire at 65. Other industries, such as accounting, also have mandatory retirement policies that are controversial and are being re-examined. The law allows the Equal Employment Opportunity Commission to consider other reasonable exemptions.

Given the high-risk nature of practicing medicine, some are asking if mandatory cutoff ages and cognitive and physical examinations are needed. More than 99,500 physicians in 2014 were still practicing in their 70s and beyond, according to estimates in the Journal of Medical Regulation (PDF), a publication of the Federation of State Medical Boards. That was up about 2% from 2012.

“The general public thinks we police ourselves better than we actually do. The reality is we don't do everything we should,” said Dr. Mark Katlic, chief of the surgery department and director of the geriatric surgery center at Sinai Hospital. That 504-bed Baltimore facility is owned by LifeBridge Health, a system that in 2014 launched the novel aging-surgeons program where Englewood Hospital and Medical Center decided to send Dardik.

Dardik's initial negative reaction didn't surprise Katlic. “We all face an inexorable decline in our physical and cognitive function. It's a fact of life,” he said. “But doctors don't always believe it.”

The mean age of retirement for U.S. physicians increased steadily from 63 to 68 from 2003 to 2014, according to the Association of American Medical Colleges. The aging workforce is likely to become more noticeable in the years ahead.

A 2015 report from the American Medical Association showed that poorer performance on quality measures such as mortality and length of stay were more apparent for clinicians age 60 and older, especially among those performing low volumes of the procedures.

Its policymaking body, which consists of 540 physicians appointed by each state medical association and medical specialty association, is in the early stages of identifying research opportunities to inform preliminary guidelines for assessing senior and late-career physicians.

Likewise, in January the American College of Surgeons recommended that surgical specialists undergo voluntary and confidential baseline physical examinations at regular intervals starting between ages 65 and 70.

“There can't be a one-size-fits-all solution,” said Dr. Vikas Saini, president of the Lown Institute, a group that advocates for a more patient-centered healthcare system. “It sounds reasonable in theory. But I'm not sure we want to retire people when they might have some of the most rich experience and understanding in the field.”

Still, most experts who spoke to Modern Healthcare shared examples of problematic incidents with elderly doctors. There was the surgeon who fell asleep during an operation; another who couldn't remember the way to his own office and had to be led there by residents; and an obstetrician who did not have the physical dexterity to deliver a baby.

“Most of us have known a physician in our careers who probably should have retired well before they did,” said Dr. Ann Weinacker, vice chair of medicine for quality implementation for Stanford Health Care. The Palo Alto, Calif.-based system was an early adopter of a late-career practitioner policy. Such initiatives are proliferating, but they are not easy to implement, partly because being a physician “is not just what we do, it's who we are,” Weinacker said. “The idea of someone saying, 'You can't do that anymore' is frightening.”

While industry leaders oppose the government setting mandatory retirement ages for clinicians, there is support for hospitals and health systems to introduce mandatory objective evaluations. Stanford and other systems are already trying to figure out best practices and are working with their attorneys to create programs that don't break federal law. In 2011 the University of Virginia Health System in Charlottesville made physical and
cognitive exams mandatory every two years for medical staff age 70 and older. Lucile Packard Children's Hospital of Stanford Children's Health introduced a similar policy around the same time; that policy was extended to Stanford Hospital and Clinics two years later. The Texas A&M Rural and Community Health Institute in College Station, the Pittsburgh-based UPMC system and Children’s Hospital & Medical Center in Omaha, Neb., have similar policies.

The policies vary in terms of the ages at which clinicians begin screening and what the exams require. Some call for clinicians to complete clinical skill and physical health screening every couple of years. Others require a more controversial cognitive test, which the AMA is leery of supporting.

Practitioners at some institutions are allowed to be tested by their own primary-care physician. Other institutions have outside physicians conduct the exams to avoid awkward peer-to-peer encounters.

The exams may take only a half day at one institution, but several days at another. Some programs solicit peer reviews ranging from a few to more than a dozen of the practitioner's clinical counterparts. “There's no blanket rule. What that means is that we need some kind of uniform way of judging,” said Saini of the Lown Institute. “But we don't do that even for younger doctors.”

That concern was shared by the Consumers Union's McGiffert. While medical licenses must be renewed regularly, competency exams are not required after the initial process. “The fact that somebody gets a medical license in their 20s and never has to prove their competency again until they are 70 is pretty weird, especially because the profession changes so much,” McGiffert said.

As groups representing hospitals and clinicians consider standardizing the efforts, facilities that want to proactively introduce late-career practitioner policies must recognize that “it's not for the faint of heart,” Weinacker said. “It's a touchy subject, it's not easy to implement, and it's not always popular.”

Though Stanford Health Care initially included a cognitive screening, that aspect was ditched the following year because of disagreement over whether it was a strong indicator of performance. Instead, they bolstered the peer-review process and now seek feedback from eight to 10 of the practitioner's colleagues. To gather, assimilate and review all that data is also “logistically very time-consuming,” Weinacker added.

LifeBridge Health's aging-surgeons program takes two days. Practitioners can travel from anywhere in the country to voluntarily participate, or it can be recommended for a surgeon by leadership. The mere recommendation can be infuriating for long-time practitioners. “At least half a dozen surgeons voluntarily retired when threatened with our program, rather than go through it,” Katlic said.

That particular program also comes with a hefty $17,000 price tag. “There is absolutely a financial burden,” said Harris, the surgical chief at Englewood Hospital. That facility's surgeon, Dardik, reluctantly became the first (and so far, the only) Englewood physician to go through LifeBridge's aging-surgeon program launched two years ago.

However, Harris says it was worth the investment.

Dardik did well on the exam, allaying any concerns that his physical and cognitive health might be a patient safety concern. He did recently decide to shift some of his responsibilities and now spends more time on training and education with another physician taking the role of chief of vascular surgery.

Dardik also became an advocate who encourages his colleagues to consider it. That ultimately saved Harris from potentially losing a swim-off with his now 80-year-old counterpart.

“I was not going to take that bait,” Harris said. “He swims every day, and there's no way I was going to be able to keep up with him.