Practitioner Health

GETTING PRACTICAL WITH

MEDICAL STAFF

GOVERNANCE, CREDENTIALING & PEER REVIEW

Practitioner Health

More Important Than Ever

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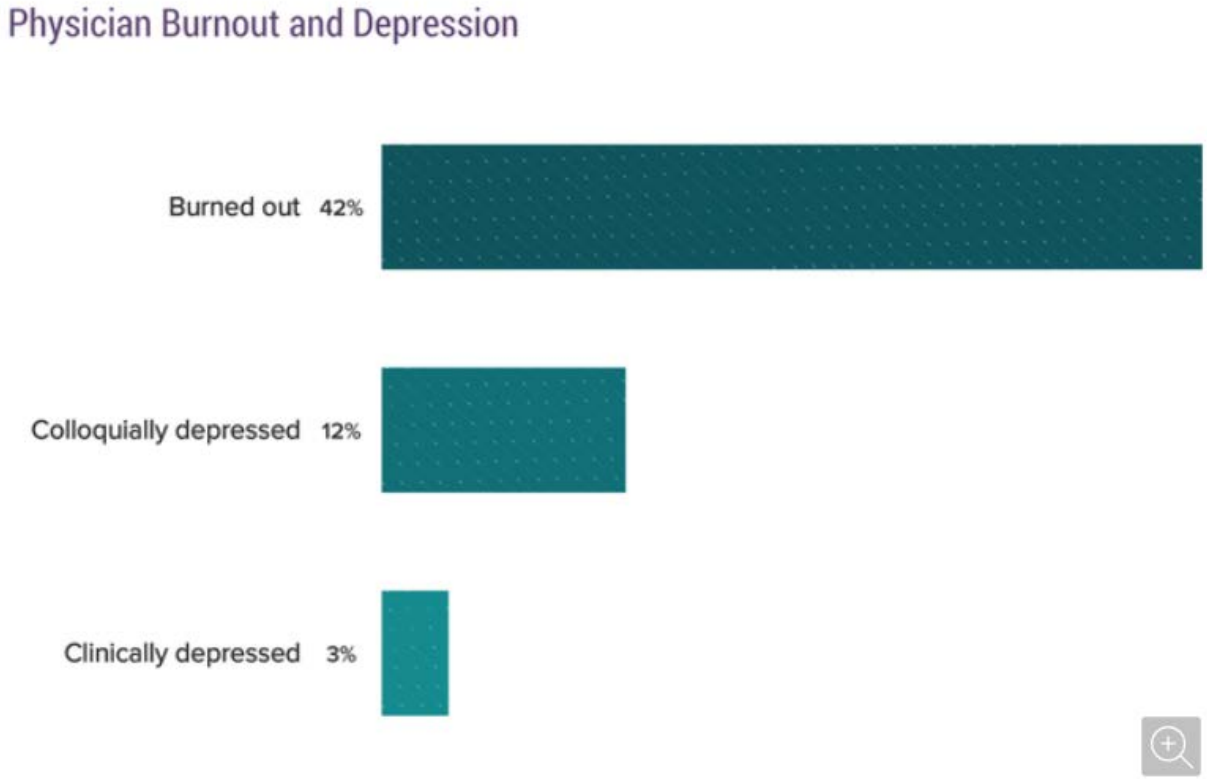
Overview

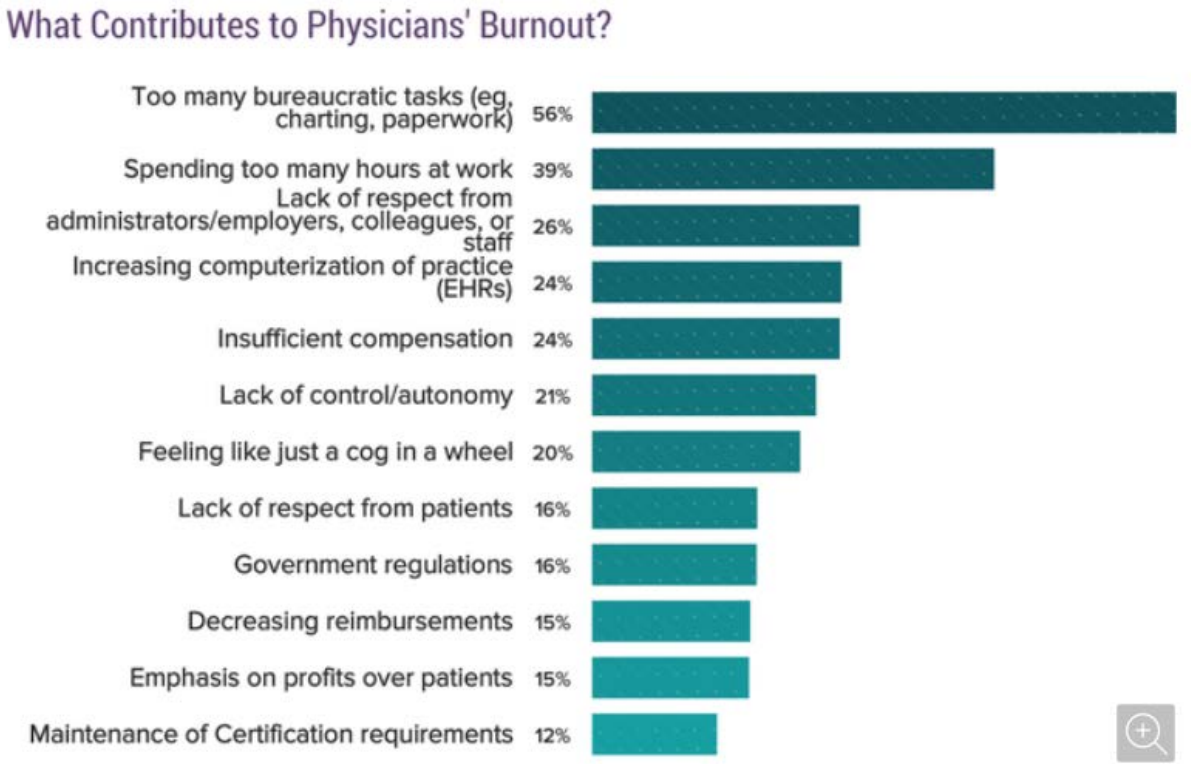
- Our National Health Crisis
- Sources of Impairment
- Signs of Impairment
- Appropriate Intervention
- What's the Process?
- The Aging Practitioner

Prevalence of Burnout

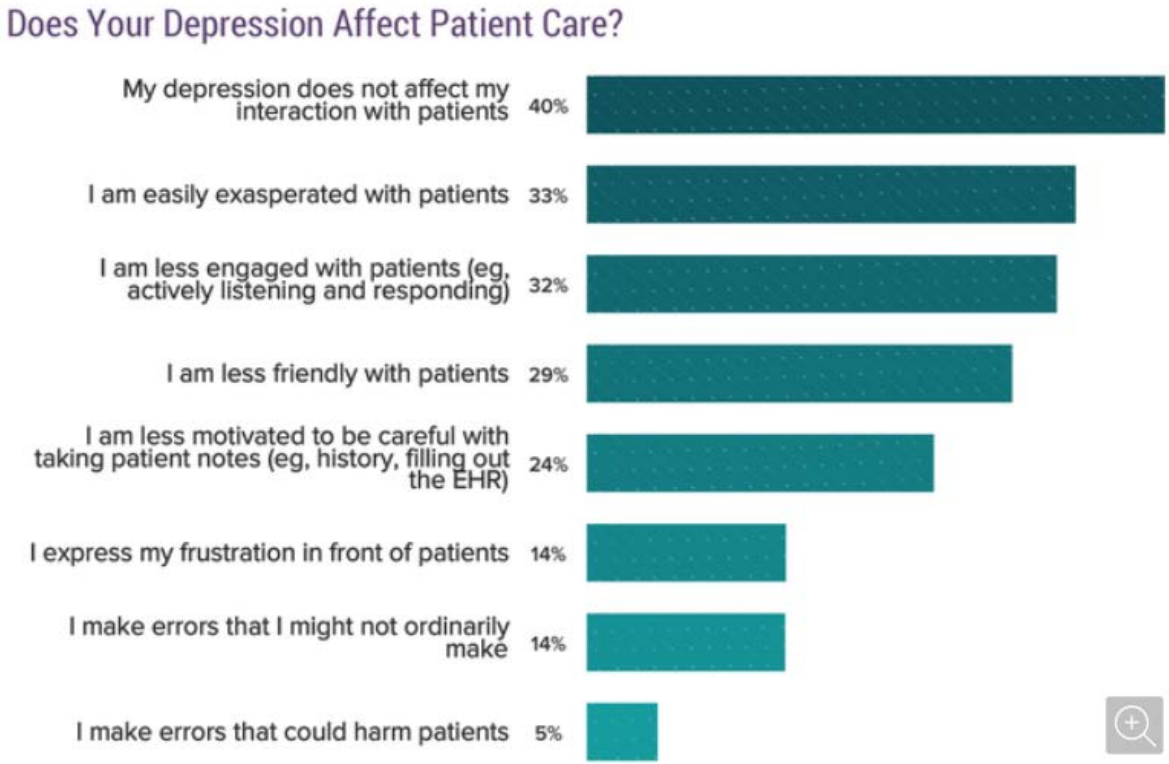


Source: Medscape National Physician Burnout & Depression Report 2018

Contributors



Impact on Care



Wellness and Burnout: It's Serious

Doctors' Suicide Rate Highest of Any Profession

By Pauline Anderson

FROM THE WEBMD ARCHIVES

May 8, 2018 -- One doctor commits suicide in the U.S. every day -- the highest suicide rate of any profession. And the number of doctor suicides -- 28 to 40 per 100,000 -- is more than twice that of the general population, new research shows. The rate in the general population is 12.3 per 100,000.

Doctors who die by suicide often have untreated or undertreated depression or other mental illnesses, a fact that underscores the need for early diagnosis and treatment, says study researcher Deepika Tanwar, MD, of the psychiatric program at Harlem Hospital Center in New York.

Physician Suicide

- On average, nearly 400 physicians commit suicide each year; a doctor a day
- 2x or more higher than the general population

  ***Source: Healthcare industry takes on high physician suicide rates, mental health stigma*; Modern HealthCare, September 29, 2018;** https://www.modernhealthcare.com/article/20180929/NEWS/180929901
- Average medical school class size is 120 students: 400 physicians = ***3.3 entire medical school classes*** needed just to replace physicians who take their own lives annually
- Why Do Doctors Commit Suicide?, P. Sinha, September 2014 https://www.nytimes.com/2014/09/05/opinion/why-do-doctors-commit-suicide.html

Leadership Response

- Situational assessment – identify the risks present in your organization
- Evaluate effectiveness (or presence) of current programs
- Identify ways to influence:
  - Physician autonomy: ability to influence work environment
  - Adequate support services: nursing, secretarial, administrative, social work, ancillary services
  - Collegial work environment: healthy relationships and common goals
  - Value oriented: core values as part of the mission
  - Promoting work-life balance: ensuring vacation time and limiting overtime, establishing mentoring, considering periodic sabbaticals

Leadership Response

- Goal: develop a "culture of wellness"
  - Well-being programs on stress management and resiliency training, finding purpose in your work, mindfulness in medicine and practicing gratitude
- Do your homework: noteworthy resources
  - Mayo Clinic: *Program on Physician Well-Being*
  - AMA's Moving Medicine Podcast
  - National Academy of Medicine's Collaborative on Clinician Well-Being
  - ACP's resource list

Impairment

- Inability to practice medicine with reasonable skill and safety
- An estimated 30% of physicians will have a condition that impacts their ability to practice at some point in their career (AMA)
- Addiction impacts 15% of the general population; higher with health care providers
- Many sources

Sources of Impairment

- Alcohol
- Drugs
- Psychological/Emotional Health
- Aging

Sources

Drugs and Alcohol

- Prevalence of alcohol and/or illegal drug dependence for physicians is similar to that for the general population *Medical Student Research Journal, January 2014*
- In 2015, there were approx. 879,000 active physicians in the United States, which means there are approx. 130,000 physicians with drug and alcohol abuse issues

Sources

Drugs and Alcohol

- Anesthesiologists and ED physicians are 3 times more likely to abuse substances that the remaining population of physicians – Fentanyl, Sufentanil
- Substance abuse is the most frequent reason a physician is subject to disciplinary action by state medical licensing boards
- 17% Physicians (N = 1900) report personal knowledge of impaired physician in past 3 years
- 1/3 didn't report it *JAMA, July, 2010*

Sources

Psychological/Mental Health

- Depression among physicians parallels that of general population – 12% *Current Psychiatry. 2011 April;10(4):16-30*
- Suicide risk is much higher – *see above*

Sources

Psychological/Mental Health

- "The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits"
  DSM V

Sources

Psychological/Mental Health

- Antisocial Personality Disorder
- Narcissistic Personality Disorder
- Borderline Personality Disorder

Signs of Impairment

Alcohol

- Alcohol on breath
- Slurs speech
- Tremors
- Hidden bottles
- Poor hygiene
- Memory blackouts
- Tardiness
- Mood swings
- Irritability
- Unexplained absences
- Isolation
- Leaving work (unexcused)

Signs of Impairment

Opiates

- Agitation
- Dilated pupils
- Pinpoint pupils
- Sweating
- Frequent bathroom breaks
- Unexplained absences
- Volunteering to clean operating rooms
- Rummaging in trash
- Excessive patient narcotic use
- Patients arriving post-op with disproportionate pain

Signs of Impairment

Other

- Mood changes – depressed, irritability, anger
- Legal problems/arrests
- Memory or concentration issues
- Vague medical complaints – fatigue, insomnia
- Sleep loss
- Significant interpersonal difficulties
- Loss of stamina

Signs of Impairment

Other

- Unexplained or frequent absenteeism
- Disappearances – unavailable when on call, response to pages
- Failure to round on patients
- Confusing or inappropriate orders
- Failure to keep patient appointments
- Excessive OR times

Signs of Impairment

Practice Signs

- Writing or requesting colleagues provide narcotic prescriptions for themselves, family members, friends
- Failure to comply with drug wastage policy – witnesses, secrecy, unlocked drug carts
- Physician's patients require unexplained repeat or increase in narcotic dosage
- Use of large dose vials when smaller dose is available and warranted

Appropriate Intervention

- One that ensures patient safety while affording the physician the chance for effective treatment, in confidence, which allows him/her to successfully resume their practice under a program of appropriate aftercare
- Assistance Programs vs. PAC vs. Peer Review Action
- Don't underestimate the power of denial
- Practitioners with psychological or aging issues may not have the insight to recognize the issues exist – often part of the condition

Appropriate Intervention

Physicians have an ethical obligation to report impaired, incompetent and/or unethical colleagues. AMA Opinion 9.031

Appropriate Intervention

- Ideally, the issue is routed through the Medical Staff's Physician Assistance or Physician Health committees, who works in conjunction with the state physician health program to have the issue evaluated and treated*
- Some programs report physician recovery rates as high as 90%

Appropriate Intervention

- The traditional peer review or disciplinary approach is not an effective mechanism to address these issues, other than as leverage or motivation to ensure compliance with PHC directions

What's the Process?

Report → Investigate → Referral → Assessment → Treatment → Reentry → Monitor

What's the Process?

Report

- Anyone can report suspected impairment; i.e., patients, staff, other practitioners, etc.
- Initial reports are usually made verbally to a supervisor, who contacts the president and/or the administrator on-call
- The reporter should document the incident ASAP, including time, date of occurrence, where the incident occurred, witnesses present, basis for the suspicion and their name
- The president or administrator should immediately come in to see the physician after first ensuring the physician will not see any patients pending their arrival

What's the Process?

Investigate

- The president and/or administrator meet privately with the physician ASAP after the report, i.e., within minutes
  - Ask if the physician has consumed drugs or alcohol recently
- They also meet with the reporter (incident report to follow) and other witnesses
- Physician may be directed to provide blood or urine sample, under supervision, for immediate testing
- Physician may be sent home and others requested to attend to his/her patients
- President and/or administrator may convene meeting of PHC ASAP, share the results of initial investigation, request physician to attend to respond to concerns and questions
- Where appropriate, consult with state resources

What's the Process?

Referral

- Where evidence suggests, direct physician to contact state PHC and voluntarily suspend practice pending assessment and treatment
- What if physician is not willing to do so voluntarily?
  - Summary (and potentially indefinite) suspension on basis physician poses an imminent threat to health, safety or welfare of patients (see Medical Staff Bylaws)
  - This avenue triggers fair hearing rights and, potentially, a report to the National Practitioner Data Bank and state licensing board
- Some programs require/expect that PHC (or MEC) will impose a suspension if physician fails to cooperate through the Assessment and Treatment process

What's the Process?

Referral

- Physician required to execute a Physician Assistance Agreement with PHC or MEC in which he/she agrees that:
  - They will immediately contact state PHC and take first available appointment
  - Medical Staff PHC/MEC may contact and share specific concerns with the state, and the state may communicate with them
  - They will follow through and cooperate with state PHC recommendations, including referrals for assessment and treatment.
  - They will voluntarily suspend their practice and use of privileges pending completion of this process and release by PHC/MEC to resume practice
  - Breach of the Agreement may result in suspension of privileges, fair hearing rights and a Data Bank report

What's the Process?

Assessment

- PHP has an intake process to determine the nature of the issue, i.e., drugs, alcohol, psychological so they can make a referral for further assessment to the appropriate program
- In some instances, the program handles the issue through referral to more local resources and state PHC follow-up
- However, referrals to regional or national programs is also common, depending on the nature and severity of the issue
  - Pinegrove, Hattiesburg, MS
  - AMITA Health Behavioral Health Institute, Chicago, IL
  - Professional Renewal Center, Lawrence, KS
- What if physician refuses to cooperate?
  - Reported to state licensing board

What's the Process?

Assessment

- The Assessment may be multi-disciplinary and include:
  - Complete medical examination
  - Battery of psychological testing
  - Psychiatric evaluation
  - Family therapy
- The Assessment Program should be allowed/encouraged/required to contact the Hospital PHC to obtain their perspective on the issues
- The hospital PHC should be allowed to obtain copies of any Program evaluations, reports or recommendations

What's the Process?

Assessment/Treatment

- Sometimes, the process ends with Assessment – find no issue. More frequently, Assessment evolves into recommendations for treatment
- So, duration of this part of the process is difficult to predict – depends on the results
- And…the physician is typically financially responsible for the costs involved
  - If employed, consider FMLA, disability and sick time benefits

What's the Process?

Treatment

- The Program releases the physician, with a recommendation or prescription for aftercare to manage and monitor the issues identified
- That recommendation goes to the state program, which enters into a written agreement with the physician which implements the recommendation and the physician agrees to their monitoring and oversight
  - AA, NA, 12 step program meetings
  - Counseling
  - Assignment of mentor
  - Random testing
  - Practice modifications

What's the Process?

Re-Entry

- The state program will release the physician to resume practice, with recommendations and notify the hospital PHC/MEC
  We review the oversight/monitoring requirements, require that the PHC/MEC have a right to contact and share and receive information with the state PHC, including random test results
- Physician enters Monitoring Agreement with the PHC/MEC, which grants rights to:
  - Random testing
  - Assign mentor
  - Communication with counselors, state PHC, etc.
  - Consequences for physician breach of Agreement

What's the Process?

Monitor

- Oversight may seem to be intrusive and to a degree, somewhat insulting
- Successful recovery requires independent oversight, testing, monitoring – maybe for years
  - The goal is a successful recovery
  - Potential for relapse is life long

Takeaways

- Have a physician assistance policy (that makes sense)
- Appoint a physician wellness committee
- Educate staff about risks and signs of impairment
- Encourage good faith reporting


OK, BOOMER

Overview

- Understand the changing demographics of the physician workforce
- Review recommendations related to screening and comprehensive evaluations
- Identify potential strategies and approaches to address concerns about performance decline in older physicians

Aging Physician Population

- The total number of physicians 65 and older more than quadrupled from 1975 to 2013
  McDade, Competency and the Aging Physician, Report of the Council on Medical Education (2015) ("AMA Report"), p. 1.
- "Research shows that between ages 40 and 75 years, the mean cognitive ability declines by more than 20%, but there is significant variability from one person to another, indicating that while some older physicians are profoundly impaired, others retain their ability and skills"

  Jama Surg. 2017; 152(10)

Physician Workforce Is Aging

FSMB Study of Actively Licensed Physicians 2014

- 50% of actively licensed physicians are over 50
  - Age 50 – 59 24% 216,643 physicians
  - Age 60 – 69 20% 182,918 physicians
  - Age 70 – 79 11% 99,554 physicians

AMA Physician Characteristics and Distribution 2015

- 1 out of 4 physicians is older than 65
- Total number of physicians over age 65 is 240,000
  - 4 times the number in this age group in 1975
  - 95,000 are still engaged in patient care
  - 10,000 - 15,000 are actively practicing surgeons
    - Some are in their 80s and 90s

Impact of Aging on Clinical Competence

The Dilemma

- Older physicians bring substantial insight and experience
- They are respected members of the medical staff

However,

- Age *does* impact cognition and clinical function
  - Which can impact patient care and patient safety
- Many physicians are staying in practice longer
- Many physicians may not recognize changes in their skills

A Fork in the Road

- Keep late career physicians on medical staff and face potential patient safety concerns

or

- Implement screening or testing policies with the risk of losing those physicians – causing physician vacancies or loss of income

Normal Aging

- Normal aging involves declines in processing speed, memory, executive function, motor control
- Pathological processes, such as Alzheimer or vascular disease, can accelerate this decline
- Chronic diseases, and medications to treat them, also impact function

All of which could potentially impact a physician's practice

Surgical Skills Impacted by Aging

- Surgery requires solid mental and physical abilities
- Fine motor skills to use sharp scalpels
- Endurance is essential for long procedures
- Quick reaction times to identify problems
- If there is a problem, must analyze the situation and make decisions swiftly

Dr. Mark Katlic, interview, When Should Surgeons Stop Operating? Shots, Health News, NPR o6.18.2015

Factors Associated with Aging

- Factors associated with aging that limit ability to engage in analytical processes
  - Decreased working memory and ability to store/process information
  - Decreased processing speed – limiting ability to complete complex tasks
  - Increased difficulty to inhibit irrelevant information and inappropriate responses
    - Tendency to be overly influenced by the order in which information is received
    - Biased by personal experience
  - Declining hearing and visual acuity
- Studies also show manual dexterity and visuospatial ability decreases with age

AMA Council on Medical Education Report 5

Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians. April 2015

Warning Signs

- Warning signs of decreasing competence may include:
  - Forgetfulness
  - Unusual tardiness
  - Evidence of poor clinical judgment
  - Major changes in referral patterns
  - Unexplained absences
  - Confusion
  - Change in personality
  - Disruptiveness
  - Drastic change in appearance
  - Unusually late and incoherent documentation

American College of Surgeons; About ACS ;Statements of the College; Statement on the Aging Surgeons Online January 1, 2016

Aging Differently…

Making Decisions to Limit Practice

Late career doctors tend to compensate for age:

- See fewer patients
- Focus on patients with less acuity
- Spend more time with patients
- Stop doing lengthy surgeries
- Limit their work schedule (fewer days, shorter days)

But some may not recognize their decline or make changes quickly enough…

Is Testing the Answer?

It's Hard…

"Overall, physicians support the professional commitment to report … impaired or incompetent colleagues…; however, when faced with these situations, many do not report"

- Reasons for not reporting
  - Someone else will take care of it
  - Nothing will happen if I do report it
  - Fear of retribution

Physicians' perceptions, preparedness for reporting, and experiences relating to impaired and incompetent colleagues. DesRoches, et al., JAMA. 2010;304(2):187-193

Age alone should not determine whether a physician is allowed to continue in practice

Hospitals are responsible to determine impact of age on practice

So What Are the options?

Screening vs. Comprehensive Evaluation

- Screening: for everyone over a specific age
  - Some hospitals have implemented "late career" or "senior" physician policies
- Comprehensive Evaluation: after lapses or when concerns arise
    - Health evaluation
    - Competence evaluation
    - Aging physician evaluation

Forced Retirement?

- AMA and others do not support a specific age cut-off for retirement from practice
- Some practice groups do have mandatory retirement policies
  - Anesthesia Service Medical Group (ASMG)
    - 240 anesthesiologists; San Diego County
    - Must leave the group at 70th birthday
  - Southern California Permanente Medical Group
    - Must resign partnership at age 65
    - Can continue on contract or per diem basis

Mandatory Screening Policies

Public Safety … Pilots

- Fair Treatment of Experienced Pilots Act
  - Age 65: Mandatory retirement
  - Age 45: First class medical certificate renewed every 6 months
  - Training to ensure acceptable skill and judgment

Controversial?

- "Older physicians aren't the problem…mid career physicians are responsible for a disproportionately higher number of bad outcomes…"
- "My memory isn't as good as it used to be and I don't play basketball anymore, but that doesn't mean I'm not competent to practice medicine…you learn to compensate."
- "If I start to lose it, my colleagues would tell me."
- "Doctors say they'll know when they need to quit, but in many cases they won't do it."
- "People don't know when they're becoming a blithering idiot. If you're impaired, you're the last person to notice."

Age-Based Policies

- In many cases, hospitals that initiated policies "had an issue with an older doctor who was incapacitated but had not yet gotten into trouble…This was a ticking time bomb."
  - *Jonathon Burroughs, M.D., health care consultant*
- Hospitals face push back from doctors
- Hospitals need to put patient safety ahead of physician autonomy
- It is critical that they have a formal, written policy on age-based testing

Should Doctors Be Tested for Competence at Age 65?

Medscape 848937, 10.28.2015

Age-Based Screening

- Decide age (65, 70, 72, 75)
- Decide frequency (annually, every 2 years)
- Decide elements
    - Cognitive function screen
    - Physical exam
        - By qualified, impartial evaluator
        - Evaluator should know physician's specialty
    - Chart review
    - Observation in practice (FPPE)
    - Peer evaluation
    - Other

Caution with Age-Based Evaluations

- Medical Staff has both employed and non-employed physicians
- Standard age applied to all physicians is likely not narrow enough to meet ADEA exception, i.e., impact of dexterity issues for a Psychiatrist v. Neurosurgeon differ substantial
- Include language in Medical Staff Bylaws that allow mental and physical health evaluation
- Use OPPE, FPPE and quality reports to identify physicians with concerns and then require mental or physical evaluation

What Happens if They Don't Pass?

- Physicians who do not pass the screen may be
  - Referred for more comprehensive evaluation
  - Required to complete remediation
  - Required to limit privileges
  - Asked to retire
- Depends largely on the severity of the concerns identified in the screen

Comprehensive Evaluation

Which Option Is Best?

- Health Evaluation
- Clinical Competency Evaluation
- Aging Physician Evaluation

Determine Fitness to Practice

Competence Assessment

- When skills or abilities have been questioned
- Returning to practice after health issue
- Assess competence in practice
- Determine impact of health issues on ability to practice
- Remediate deficiencies

Physician Health Evaluation

- Evaluate physical and mental health
- Structure monitoring process and compliance
- Determine ability to practice with skill and safety

Similar purpose . . . Different focus

Physician Health Programs

- Provide peer assistance services
- Aid individuals who have problems that could affect health and ability to practice
- Offer assessment, referral, monitoring and support services
- Non-disciplinary and confidential
- Some perform Fitness for Duty Evaluations
  - Focus on health and mental health evaluations
  - Assessment of ability to practice safely

Conclusion

- Physician population is aging
- Your options vary:
  - Mandatory screening
  - Comprehensive health, competence or aging evaluation
- Policies should ensure older physicians are treated in respectful, objective and confidential manner

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Please visit the Hall Render Blog at https://www.hallrender.com/resources/blog/ for more information on topics related to health care law.

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