REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Competency of Senior Physicians
(Reference Committee C)

EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician's competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others that are not evidenced based.

The Council on Medical Education studied this issue and prepared its first report on this topic in 2015. American Medical Association (AMA) Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," was adopted and the Council, in collaboration with the Senior Physicians Section, identified organizations to work together to develop preliminary guidelines for screening and assessing the competency of the senior/late career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report also outlines a set of guiding principles developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for the development of guidelines for screening and assessing senior/later career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-18

Subject: Competency of Senior Physicians

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

American Medical Association (AMA) Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," directs our AMA to: "1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and 2) convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings."

The first report on this topic, Council on Medical Education Report 5-A-15, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," recommended that a work group be convened to further study the topic of assessing the competency of senior/late career physicians. This report summarizes the activities of the work group and additional research findings on this topic. This report also outlines a set of guiding principles to provide direction and serve as a reference for the development of guidelines for screening and assessing senior/later career physicians.

BACKGROUND: SCOPE OF THE ISSUE

Older physicians remain an essential part of the physician workforce. The total number of physicians 65 years and older has increased greatly from 50,993 in 1975 to 300,752 in 2017.[1] Physicians 65 and older currently represent 26.6 percent of all physicians in the United States.[1] Within this age group, two-fifths (40.6 percent) are actively engaged in patient care, while half (52.7 percent) are listed as inactive in the AMA Physician Masterfile.[1] Many physicians are hesitant to retire and may continue to practice into their 70s and 80s due to professional satisfaction, increased life expectancy, and concerns regarding financial security.[2]

Evidence supports findings that physical health and some cognitive abilities decline with aging.[3] Research shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.[4] The effect of age on any individual physician's competence can be highly variable, and aging is just one of several factors that may impact performance.[2,5] Other factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.[6,7] Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.[7] Performance also may be broadly determined by characteristics ranging from intelligence to personality.[3] However, some attributes relevant to the practice of medicine—such as

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wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of aging.[5,8-11]

Although age alone may not be associated with reduced competence, the variation around cognitive abilities as physicians age suggests that the issue cannot be ignored. There are a limited number of valid tools for measuring competence/performance, but these tools are primarily used when a physician is "referred for cause." In addition, physicians' practices vary throughout the United States and from specialty to specialty. A few hospitals have introduced mandatory age-based evaluations, but there is no national standard.[12-13] Furthermore, there is cultural resistance to externally imposed assessment approaches and concern about discriminatory regulatory policies and procedures.

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.[14] For this reason, physicians with decades of experience and contributions to medicine and to their patients, as they experience health changes that may or may not allow continued clinical practice, deserve the same sensitivity and respect afforded their patients.[15] Shifting away from procedural work, allocating more time with individual patients, using memory aids, and seeking input from professional colleagues might help physicians successfully adjust to the cognitive changes that accompany aging.[5,14]

It is in physicians' best interest to proactively address issues related to aging in order to maintain professional self-regulation. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation.[16] Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and new and evolving maintenance of certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

WORK GROUP MEETINGS

To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration with the Senior Physicians Section, identified organizations to participate in a joint effort to develop preliminary guidelines for screening and assessing the senior/late career physician. As summarized below, one work group meeting and two conference calls were convened to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines supported by research findings.

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates as well as content experts who research physician competence and administer assessment programs. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of senior physicians, which are challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and preliminary research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians' competence and practice performance. In

addition, the participants felt that a set of guiding principles should be developed to reflect the values and beliefs underlying any guidelines that may be developed for screening and assessing senior/late career physicians.

July 19, 2016 Work Group Conference Call

The purpose of this conference call was to convene a smaller group of participants to develop guiding principles to support the subsequent development of guidelines to screen and assess senior/late career physicians. During the call, the conversation focused upon the thresholds at which screening/assessment should be required. Although physicians of all ages can be assessed "for cause," the group discussed whether age alone is a sufficient cause for some kind of monitoring beyond what is typical for all physicians. Other factors discussed included the influence of practice setting and medical specialty, as well as the metrics and standards for different settings that would have to be developed to determine at "what age" and "how do you test," etc. The need for surveillance, associated risk factors, and the ability to take appropriate steps, if needed, were also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians who may need help while assuring patient safety. It was also noted that very few hospitals have specific age guidelines, and that there was evidence that the number of disciplinary actions increase at ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

The group felt that more information and data were needed before the guiding principles could be finalized and agreed to reconvene after gathering more information and studying evidence-based data from the United States and other countries related to age and risk factors.

December 15, 2017 Work Group Conference Call

The purpose of this conference call was to reconvene the same smaller group of participants to review the literature and data that had been gathered, and to finalize guiding principles to support the subsequent development of guidelines to screen and assess senior/late career physicians. Background information to help guide the development of the guiding principles included:

1. Results from a survey of members of the Federation of State Medical Boards (FSMB), Council of Medical Specialty Societies (CMSS), and International Association of Medical Regulatory Authorities (IAMRA) regarding the screening and assessment of senior physicians.

2. A literature review of available data related to senior physician screening and assessment, focusing on international work in this area.

3. Data from large health systems regarding their screening and assessment policies and procedures.

<u>Survey Results Related to Screening and Assessing Senior Physicians</u>

To support the development of guiding principles, data were gathered through surveys of professional associations (CMSS), state medical boards (FSMB), and international regulatory authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen and assess senior physicians for clinical or cognitive competence, and if not, whether they had thought about developing such screening and assessment processes.

The survey data showed that most respondents were not screening or assessing senior physicians. A slightly larger number of respondents have thought about this, but those numbers were still fairly small.

Most respondents did not have clinical or cognitive screening/competence assessment policies in place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent) whether other organizations had age-based screening in place. Regarding whether age-based screening should be included within physician wellness programs, 28 (32.9 percent) said yes, while nine (10.6 percent) said no, and 48 (56.5 percent) were unsure.

Respondents were asked if their organizations/boards offered educational resources regarding the effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in having resources that promoted physician awareness of screening aging physicians in practice. Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents, 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested in offering them.

Highlights from the Literature Review

A review of current literature focusing on age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally is summarized below.

Peer-reviewed studies recently published focus on institutional policies related to cognitive assessment of senior physicians. Dellinger et al. concluded that as physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers regarding wellness and competence would be beneficial both to physicians and their patients.[17] The authors also recommended that large professional organizations identify a range of acceptable policies to address the aging physician, while leaving institutions the flexibility to customize the approach.[17] Institutions such as Cooper University Health Care in Camden, New Jersey, are developing late career practitioner policies that include cognitive assessment with peer review and medical assessment to assure the hospital and physicians that competency is intact and that physicians can continue to practice with confidence.[18]

Studies related to professionalism, self-reporting, and peer review indicate that these methods are not always reliable.[16, 19-20] Since early “red flags” of cognitive impairment may include prescription errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged improved reporting of impaired physicians by patients, peers, and office staff.[2] LoboPrabhu et al. suggested that either age-related screening for cognitive impairment should be initiated, or rigorous evaluation after lapses in standard of care should be the norm regardless of age.[21]

Any screening process needs to achieve a balance between protecting patients from harm due to substandard practice while at the same time ensuring fairness to physicians and avoiding any unnecessary reductions in workforce.[3] A recent study of U.S. senior surgeons showed that a steady proportion of surgeons, even in the oldest age group (>65), are still active in new surgical innovations and challenging cases.[22] Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.[23-24]

In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. Adler and Constantinou note that normal

aging is associated with some cognitive decline as part of the aging process, but physicians, who are highly educated individuals with advanced degrees may be less at risk.[14]

A review of the aging psychiatric workforce in Australia showed how specific cognitive and other skills required for the practice of psychiatry vary from those applied by procedural specialists.[25] The Australian medical boards are responsible for protecting the public from unsafe medical practice. There is some uniformity in the way that Australian regulatory bodies deal with impairment that supports the dual goals of protecting the public and rehabilitating the physician.[26] However, there are no agreed upon guidelines to help medical boards decide what level of cognitive impairment in a physician may put the public at risk.[14] In Australia, the primary approach to dealing with older physicians (age 55 and older) is individualized and multi-levelled, beginning with assessment, followed by rehabilitation where appropriate; secondary measures proposed for older impaired physicians include early notification and facilitating career planning and timely retirement.[26]

It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use reasonable methods to determine whether performance remains acceptable.[27] However, high performance by all physicians throughout their careers cannot be fully ensured.

A better understanding of physician aging and cognition can inform more effective approaches to continuous professional development and lifelong learning in medicine—a critical need in a global economy, where changing technology can quickly render knowledge and skills obsolete.[4] The development of recertification programs, such as maintenance of certification (MOC) by the member boards of the American Board of Medical Specialties, provides an opportunity to study the knowledge base across the professional lifespan of physicians.[28-29] For example, a recent study of initial certification and MOC examinees in the subspecialty of forensic psychiatry using a common item test question bank compared the two examinee groups' performance and demonstrated that performance for those younger than 50 was similar to those 60 and older, and that diplomates recertifying for the second time outperformed those doing so for the first time.[30]

The Royal Australasian College of Surgeons developed strategies to support senior surgeons over 65 years of age (expected to be about 25 percent of surgeons by 2050) and a position statement that provides clear guidelines to aging surgeons, with a focus on continuing professional development.[31-32] An assessment of the competence of practicing physicians in New Zealand, Canada, and the United Kingdom showed that "maintenance of professional standards" by continuing education did not identify the poorly performing physician; rather, assessment of clinical performance was needed.[27] The most common approach to assessment may be responsive—following a complaint—or periodic, either for all physicians or for an identified high-risk group. However, a single, valid, reliable, and practical screening tool is not available.[27]

A literature review conducted in Europe to explore the effects of aging on surgeons' performance and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age, suggested that competence should be assessed at an individual level, focusing on functional ability over chronological age; this may inform retirement policies for surgeons, which differ worldwide.[22] Research conducted in Canada suggested that some interventions (external support, deliberate practice, and education and testing) might prove successful in remediating older physicians, who should be tested more thoroughly.[33]

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition of timing into retirement in the United States.[23,34] A literature review that looked at retirement ages for doctors in different countries found that there is no

mandatory retirement age for doctors in most countries.[35] Anecdotal reports published in the *British Medical Journal* suggest that retirement has never been easy and is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement.[36-37] In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector.[35] In Russia and China, the mandated retirement age is 60 for men and 55 for women.[35]

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.[14] Peisah, et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the problem of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors.[26] Racine (Canada) suggested that physicians retire before health or competency issues arise.[38] Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family.[39] The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late-career surgeons to engage in greater levels of teaching, research, and administration.[40]

How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of Senior Physicians

Since the call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice,[5] the work group concurred that it was important to investigate the current screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening,[12-13] but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons. Recognizing that the average age of the practicing surgeon is rising and approximately one-third of all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence competency and occupational performance. In January 2016, the ACS Board of Governors' Physician Competency and Health Workgroup published a statement that emphasized the importance of high-quality and safe surgical care.[39] The statement recognized that surgeons are not immune to age-related decline in physical and cognitive skills and stressed the importance of a healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a voluntary and confidential baseline physician examination and visual testing for overall health assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to voluntarily assess their neurocognitive function using confidential online tools and asserted a professional obligation to disclose any concerning findings, as well as inclusion of peer review reports in the re-credentialing process.[41]

The American College of Obstetricians and Gynecologists (ACOG) recommends that when evaluating an aging physician, focus should be placed on the physician's quality of care provided to patients.[42] ACOG's recommendations regarding the later-career obstetrician–gynecologist also state that: 1) it is important to establish systems-based competency assessments to monitor and address physicians' health and the effect age has on performance and outcomes; 2) workplace adaptations should be adopted to help obstetrician–gynecologists transition and age well in their practice and throughout their careers; and 3) 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.[42]

At Kaiser Permanente, within its Permanente Medical Group, physicians are classified as "in partnership" or "incorporated." In a region where a partnership exists, such as Southern California, the mandatory retirement age as a partner is at the end of the calendar year when one turns 65. Southern California Permanente Medical Group has approximately 3,000 partners, of which 300 retire each year at full retirement age. In the incorporated regions, there is no mandatory retirement for clinicians. In the partnership regions, retired physicians (partners emeritus) may apply for employment at age 66, but they are not guaranteed employment. If granted employment, these physicians see a dramatic decrease in remuneration, and they are usually not required to have a patient panel. Rehiring is at the discretion of the medical director and the budget. Therefore, a limited number of opportunities are available. Approximately 10 percent of these physicians apply for rehiring, and approximately 15 to 20 percent of those are rehired. They are usually limited to no more than 20 hours per week performing either clinical or administrative work. As a result, very few Permanente physicians work until age 70 or older.

The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program is the largest assessment and remediation program for health care professionals in the country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data analysis showed that a number of senior physicians performed less than optimally (seven of 30 participants). However, when age-based capacity was reviewed (i.e., did those individuals between 50 to 59 or those between 60 to 69 years old perform better than those age 70 and older), the results were not statistically significant. The pilot study did have sufficient power to reach significance. However, the trend of the data was that older physicians did perform less optimally. It was also noted that 75 percent of the physicians who didn't perform well on the MicroCog (a computerized assessment that detects early signs of cognitive impairment) were still working in a clinical capacity. The study did not include enough participants to provide a breakdown on specialties.

PROPOSED GUIDING PRINCIPLES

The Council on Medical Education proposes a set of guiding principles as a basis for developing guidelines for the screening and assessment of senior/later career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

The Council developed the following eight guiding principles with extensive feedback from members of the AMA Work Group on Assessment of Senior/Late Career Physicians as well as feedback from other content experts who research physician competence and administer screening and assessment programs.

1. *Evidence-based:* The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.

2. *Ethical:* Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.

3. *Relevant:* Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

4. *Accountable:* The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

5. *Fair and equitable:* The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.

6. *Transparent:* Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

7. *Supportive:* Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

8. *Cost conscious:* Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

AMA POLICY

The AMA has policy in which it urges members of the profession to discover and rehabilitate if possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions

that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are attached (see Appendix).

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered, and they are providing appropriate and effective treatment. However, data and anecdotal information support the development of guidelines for the screening and assessment of senior/late career physicians. The variations around cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are also key factors contributing to this need. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:

    a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.
    b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.
    c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
    d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
    e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.
    f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems. (New HOD Policy)

2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians. (Directive to Take Action)

3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $1,000

APPENDIX: AMA POLICIES

D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians"

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, "Physician Competence"

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, "Physician Competence"

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources

adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
(CME Rep. A, A-87 Modified: Sunset Report, I-97 Reaffirmation A-04 Reaffirmed: CME Rep. 3, A-10 Reaffirmation I-10 Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)

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