

## Memorandum

**To:** 2017 Council

**From:** James Cusick, MD, FACEP  
Speaker

John McManus, MD, FACEP  
Vice Speaker

**Date:** October 13, 2017

**Subj:** Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians

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The 2016 Council and the Board of Directors adopted Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians:

RESOLVED, That the ACEP Board of Directors create a task force to study issues specific to Senior/Late Career Emergency Physicians. The task force shall make recommendations regarding identified issues to the Board, which shall deliver an update on this matter to the 2017 ACEP Council.

Since the American Board of Emergency Medicine (ABEM) had already begun a substantial review of cognitive skill and physician age, ACEP partnered with ABEM to create a task force.

Attached is the report from the task force. The Board of Directors will review the report at their October 26, 2017, meeting. The Council will be informed if the Board does not accept the report.

## **Task Force on the Aging Physician October 2017**

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### **Introduction**

America is getting older. A “silver tsunami” is beginning to crest as the baby boomers reach retirement age. The aging American workforce includes physicians, as 23% of the physician workforce is 65 and older.<sup>1</sup> United States hospitals may be staffed with providers from up to four different generations (traditionalists, baby boomers, generation X, and millennials).

Emergency Medicine (EM) is a relatively young specialty, with a specialty board created in 1979, and as such, has had a relatively young workforce to date. In the early years, there were few residencies but great demand for emergency coverage. Individuals who practiced EM and met other educational criteria were eligible for board certification. Closing the practice-eligibility pathway led to a relatively large cohort of physicians becoming certified, followed by a sharp decrease after the grandfathering period closed. Since that time, there has been a steady increase in physicians entering the field as the number of residencies has expanded. Between 2007 and 2016, the number of American Board of Emergency Medicine (ABEM)-certified physicians aged 65 and older increased from 707 (3% of all diplomates) to 3,424 (10% of all diplomates). Given this maturation, the specialty must now consider the issues of an aging workforce, including age-related neurocognitive and physical changes that impact clinical performance.

In 2016, the American College of Emergency Physicians (ACEP) Council adopted a resolution calling on the Board of Directors of ACEP to study issues related to “senior/late career” emergency physicians. Specifically, it asked the Board to “study and determine if any specific issues posed to senior/late career emergency physicians exist,” to “address those issues in an appropriate manner,” and report its findings to the 2017 ACEP Council. What follows is that report.

In March 2017, ACEP President Dr. Rebecca Parker appointed a task force to address this resolution. Members of the task force were selected for their expertise in education, certification, geriatrics, competency, circadian rhythms, and generational relations. The group held several conference calls and met in person at the Society for Academic Emergency Medicine (SAEM) Annual Meeting in May of 2017. Early in the process, the task force determined that “aging physician” was a better term than “senior/late career physician” for the focus of the report.

Two overarching challenges face the aging emergency physician: competency and wellness. Competency is affected by cognitive decline, the ability to keep up with evolving science and technology, and physical limitations to perform procedures and cope with a shift schedule. Defining and recognizing critical skill deterioration, whether due to age, illness, or injury, is essential for professional self-regulation. Simultaneously, the specialty must promote wellness and identify reasonable accommodations that allow the aging workforce to maximize career longevity. Failure to do so risks losing decades of experience and wisdom.

### **Cognitive Ability**

Both cognitive and procedural skills are essential and likely decrease with age. Cognitive skills decline with age and many studies among physicians have demonstrated decreasing practice performance with increasing years in medical practice.<sup>2</sup> One meta-analysis found that the pooled prevalence of dementia in European cohorts rose continuously from 55 years of age.<sup>3</sup> In the US, the rate of cognitive impairment without dementia is 20% in those aged 71 and older, with 12% of these individuals progressing to dementia annually.<sup>4</sup> However, this change is quite variable, and while high intellect and life-long learning may mitigate the rate and impact of this decay, some degree of neurocognitive decline is unavoidable.<sup>5,6</sup> Importantly, the capacity to process new information and reason declines beginning in middle adult years, potentially affecting the acquisition of new knowledge.<sup>2</sup> The impact of cognitive

decay is complicated even further by the counteractive forces of experience and wisdom that improve performance over novice practitioners.

Eva identified age-related factors that could interfere with optimal cognitive function for physicians. These included: decreasing working memory, decreasing ability to store and process information, slower speed of mental operations, the tendency to be influenced by the order in which information is received (primacy effect), increased bias from personal experience, and impaired vision and hearing.<sup>7,8</sup>

Assessing a physician's medical knowledge and decision-making ability is challenging, especially when determining cutpoints for competence as many additional skills combine to impact the sophisticated care that is delivered in the time-compressed environment of the emergency department. While there are neurocognitive tests that are an objective index of a physician's cognitive skills, these are not routinely used in practice. Such assessments usually only occur when physicians are undergoing reentry into practice after a clinical hiatus; remediation after an unfavorable event or disciplinary action; or as a mandatory age-related assessment. Mandatory testing based on age is a complex issue and raises concerns about age-related discrimination.<sup>9</sup> Further it is not clear who should be testing the physicians – hospitals, physician practice groups or the individuals themselves. Beyond a recertification examination, most aging physicians receive no objective, validated data on their decision-making ability and medical knowledge.

Healthcare institutions also have a duty to monitor quality of clinical care. The AMA CME report on the Aging Physician stated that, “from a public protection perspective, the objective assessment option seems like an important intervention, given the strong impact of aging on performance, the extreme variability of cognitive function among older physicians, and the well-documented inability of physicians to self-assess...”<sup>10</sup>

The only objective assessment of medical knowledge and cognitive skills that most emergency physicians receive is the ABEM Continuous Certification Examination (ConCert). An ABEM-certified physician must take the ConCert on average at least every 10 years. Most questions on the ConCert assess complex cognitive skills (e.g., diagnostic processing, clinical synthesis), not fact recall. Just as the clinical practice of emergency medicine requires that a physician determine a diagnosis from undifferentiated signs and symptoms, most questions on the ConCert require that the physician derive a diagnosis from a clinical scenario.

A prior study showed that physicians tend to maintain their performance on the ConCert over time.<sup>11</sup> A more recent analysis shows an age-related decline, particularly around age 60 [Figure 1]. A similar age-associated decrease in examination performance has been noted in other medical specialties<sup>12,13,14</sup> The performance predication curve suggests that at age 75, there is about a 50% risk of failing the examination. Despite this trend, some physicians older than age 75 perform well on the ConCert.

Physician performance on standardized examinations has been shown to correlate with medical malpractice risk, state medical board disciplinary actions, and the quality of care.<sup>15,16</sup> Though some evidence suggests that advancing age is not associated with the risk of a malpractice suit or state medical board disciplinary action, the overall weight of the data indicates that age is a risk factor for malpractice and disciplinary actions.<sup>17,18,19</sup>

Tests such as the ConCert exam do not measure procedural competency. Physical limits with age include decreases in dexterity, vision and hearing. In addition, procedural competence may decline when procedures are not performed for years or decades.

Clinical data registries provide a unique opportunity for comparing clinical performance to a normative group. The ACEP qualified clinical data registry, called the Clinical Emergency Data Registry (CEDR), could provide norm-referenced data on the adherence to clinical quality measures. Because most clinical quality measures are still process-oriented, the degree to which this data can be used to make determinations about patient outcomes and physician competency is uncertain. Nonetheless, their use as a longitudinal physician assessment is promising.

Physicians have a professional duty to self-monitor their physical and mental fitness to practice. Because there is no age-based mandatory retirement for physicians, the decision to retire from practice is largely a self-determined event. Late-career emergency physicians face many concerns, such as difficulty recovering from night shifts, greater emotional exhaustion at the end of a shift, less ability to handle the stress of emergency medicine, and a worsening memory.<sup>20</sup> Providing information to physicians about their medical knowledge and cognitive skills could assist the physician in making important and sometimes agonizing decisions about retirement.

## **Changing Nature of CME**

It is critically important to retain knowledge and skills while acquiring new information from rapidly evolving medical science; a task made more challenging with age-related challenges in incorporating new information (reference 2). The options for obtaining Continuing Medical Education (CME) are greater today than ever before. Individual physicians have their own preferences for CME formats, such as in-person courses, journal articles, magazine articles, blogs, webinars, podcasts, and social media. Electronic media and free open access medical education (FOAMed) are increasing in popularity, while “traditional” CME sources such as in-person conferences and print media are decreasing. While the preference for non-traditional media is increasing overall, older physicians continue to prefer print media for CME.<sup>21</sup> Though some state chapters of ACEP have seen a decline in CME program attendance, the ACEP annual meeting continues to consistently post record attendance. At the same time, the College’s sales of virtual ACEP and eCME have steadily increased each year. The bottom line is that varied CME formats that appeal to different age cohorts are still desirable.

## **Procedure Skill**

In emergency medicine, there are life-saving procedures that are rarely performed. Simulation settings, such as with manikins or cadavers, are likely the only way for most emergency physicians to practice rare procedures, such as thoracotomy and cricothyroidotomy. Aging physicians face additional procedural skill challenges due to the natural decline in hand-eye coordination and the decrease in visual acuity due to presbyopia. Furthermore, new medical advances render some procedures obsolete (eg, application of MAST trousers, diagnostic peritoneal lavage) while creating a need to learn new procedures (clinical ultrasound, video laryngoscopy). Preliminary data in a study by Dr. David Sklar and his colleagues found that acquiring new information was strongly correlated with stopping the use of obsolete treatments by emergency physicians.<sup>22</sup> Observation by nurses, trainees, and colleagues is also helpful in monitoring for skill deterioration.

## **Work Flow, Productivity, and Task Switching**

Task switching, or multi-tasking skill, declines with age, and older adults may have difficulty inhibiting distracting information and interference from other tasks. Interestingly, the decrease in ability to task switch may, in part, be due to an increased number of tasks presented to the brain with maturity.<sup>23</sup> Difficulty in triaging information may be influenced by the order in which information is gathered or received, with earlier information given more weight. Information may be processed differently based on a physician’s personal experience.<sup>24</sup> For example, a less experienced physician may be confident with an ‘obvious’ benign diagnosis, while the more experienced physician may recall a person who died from a similar presentation. Interruptions are frequent in the ED and may interfere with productivity and recall of task completion.

Age-related changes with over-reliance on pattern recognition, mental algorithm use, decreasing working memory, and worsening ability to store and process information by older physicians can affect the speed of evaluation and treatment of patients, including the ability to quickly move the patient through the emergency department. While some medical decisions are safely made using experiential and “gestalt” processes, in the complex patient, non-analytic processes may lead to more accurate diagnoses. Unfortunately, unrecognized diagnostic errors can occur when pattern recognition supplants analytic processes in complex clinical situations.<sup>7</sup>

## **Circadian Rhythms, Fatigue and Sleep**

As humans age, a number of physiologic changes take place with respect to circadian rhythms, fatigue and sleep, and some of these directly affect the ease of doing shift work. With age, people shift so that they are more functional at early, rather than late, hours. Therefore, they find that early shifts are favorable. Generally, work performance or functional capacity begins to decline at age 45.<sup>25</sup>

There is reduced tolerance for longer work hours with aging.<sup>26</sup> Older workers need longer time to recover from night shifts or overtime work.<sup>27</sup> In addition, older workers may be unable to sustain the same level of performance over an entire night shift or cope with multiple successive night shifts.<sup>28</sup> Substituting 10-12 hour shifts for 8 hour shifts increases fatigue. The critical age for increasing intolerance to shift- and night- work seems to be about 45-50 years of age.<sup>26</sup>

With respect to sleep, numerous physiologic changes occur with aging. Humans begin to sleep less efficiently. This can happen if it takes longer to fall asleep or there are longer periods of wakefulness during a sleep period. Decreased sleep efficiency also occurs because a greater percentage of sleep time is spent in the lighter stages of sleep (NREM Stages 1 and 2). These lighter sleep stages result in less restorative sleep. In addition, there are more arousals from sleep during an average sleep period for our aging population. The net result is less total sleep time. In fact, total sleep time decreases an average of 27 minutes per decade from midlife until the eighth decade. As a result of these influences, there is more daytime sleepiness for people as they age, which can impact one's ability to work.<sup>29</sup>

Supporting senior physicians can be accomplished in a number of ways. Adjusting shifts can be helpful. Requiring fewer night shifts is beneficial, though it is important to do this equitably. For example, having incremental income for doing night shifts and rewarding nocturnists with non-monetary benefits can reduce the number of night shifts given to aging physicians. Non-monetary benefits for dedicated night-shift workers (nocturnists) may be an effective incentive. Shift sharing (two people split a standard shift) among our aging physicians and assigning shorter shifts should be encouraged. Limiting consecutive shifts to two is advantageous.<sup>30</sup>

### **Physical Health and Wellbeing**

With advancing age comes a greater likelihood of physical ailments. Years of shift work in the emergency department may increase this likelihood. Chronic disruptions in circadian function are associated with an increase in disease states, including heart disease, ulcers, diabetes and some cancers.<sup>31,32</sup> Sleep deprivation decreases insulin sensitivity and increases the risk for Type II diabetes. Night workers have increased risks of hypertension, indigestion, and heartburn.

Procedural and job-related injuries, due to repetitive manual procedures and long hours standing or bending, decrease productivity as years in practice increase.<sup>33</sup> Decreased fine motor skills, visual changes, and sensory function decline are part of the aging process and make daily emergency practice more difficult. Cognitive difficulties also increase with aging. Regardless of the potential causative influence of shift work, the practice environment, or the aging process itself, with increasing age comes a higher risk of physical ailments and physical changes. The effects of these age-related physical changes are sometimes hard for the aging physician to recognize or acknowledge. Because emergency physicians often practice alone or in parallel to their colleagues, the impact of these changes may not be noticed until a question of competency arises because of poor patient care or a bad patient outcome.<sup>7</sup>

Another important consideration is the impact of aging on psychological wellbeing. Physicians who practice emergency medicine have one of the highest burnout rates of all specialties. Burnout is defined as loss of enthusiasm for work, feelings of depersonalization and a low sense of personal accomplishments. A survey showed that 45.8 % of physicians reported at least one symptom of burnout and that emergency medicine has the highest rate of symptoms (65%).<sup>34</sup> However, there does not seem to be much evidence that burnout increases with age. One review of 47 papers revealed that younger age, among other things, was associated with burnout in doctors.<sup>35</sup>

### **Generations in the Workplace**

Understanding the context of aging physicians amidst a multigenerational workforce decreases conflict and increases productivity. Open communication and generational understanding help to harness the different strengths of each group. With attention to generational diversity, optimizing the role of the aging physician can be accomplished.

There are up to four groups within the workplace, each of whom display differences in ambition, enterprise, and job expectations. The four workplace generations are: Traditionalists (born before 1946), Boomers (born 1947 to 1964), Gen Xers (born 1965 to 1976), and Millennials (born 1977 to 1997). The "aging physician" includes all traditionalists and currently approximately half of the baby boomers. Generations tend to have different career goals, ideas of balance, and the need for feedback. Lancaster and Stillman summarized generalizations describing each age category (see table 1).<sup>36</sup> Understanding of the different attitudes and ambitions in the workplace is essential. Acknowledging and leveraging this diversity can create generational synergy in clinical practice. Ideally, optimizing generational contributions would lessen burnout, enhance professional fulfillment, improve professional communication, and provide better outcomes for patients and their families.

## Legal Matters

There is limited data on the association of medical-legal risk and older physicians. Some studies suggest that age is not associated with increased risk. Winta, et al, found that physicians over 60 years of age actually have a lower rate of “never events” than any other age category.<sup>37</sup> Looking at peri-operative complications, the rate of operative mortality is not significantly affected by age.<sup>38</sup> A recent study (*Annals*, in press), using an emergency medicine-only database, indicated that physicians with more years of practice had a greater likelihood of being named in a claim during the 4-year study period. The authors concluded that the total number of patient exposures was the reason for this, rather than physician-related factors.<sup>39</sup>

Other research, however, demonstrates more medical-legal problems with older age. A review of disciplinary cases by the Medical Board of California found an increased risk of disciplinary action with age.<sup>40</sup> Older physicians were more likely to be deemed “unsafe” to return to practice after review by a physician health program.<sup>41</sup> A study in the *New England Journal of Medicine* found that the risk of malpractice claims for physicians, in general, peaks at ages 45–54, with physicians under 35 having one-third the risk of their older colleagues.<sup>42</sup> This is consistent with specialty-specific data from dermatology, psychiatry, and plastic surgery.<sup>43,44,45</sup>

Although there is limited data on physician age and medical malpractice risk (as well as disciplinary actions), the majority of the research suggests that physician age increases the risk of malpractice lawsuits and state medical board disciplinary action.

## Survey of Emergency Medicine Practice / Accommodations

From the preceding review of the literature as well as practical experience, The Aging Physician Task Force confirmed that certain practice accommodations may be important for some aging physicians. To further advise this consideration, the task force developed a 10-question survey on core issues related to the aging emergency physician. The survey was distributed in May 2017 and was designed to assess how members are currently addressing the aging clinician in their own practices. Participation was voluntary and included outreach to members of the Emergency Department Practice Management Association (EDPMA), as well as others. The results of the survey questions are summarized in Table 2.

Several observations can be drawn from the survey responses. Over half of the respondents have requested hospital credentials for a physician over age 65. Similarly, over half of the respondents have implemented some type of practice accommodation for the aging physician. The most frequent accommodation was reduced night shifts, followed by reductions in the total number of shifts scheduled per month. Additional accommodations included scheduling the provider only with residents, scheduling in urgent care or fast track areas, working shorter shifts, or scheduling only double-covered shifts. Sixteen percent (16%) of respondents indicated that there were no accommodations in their group for the aging clinician.

In order to assess the cognitive skills of an aging physician, a significant majority (over 75%) rely on feedback from other physicians, nurses, and staff. Fifty-five to 68% rely on ongoing board certification or maintenance of certification. Approximately half of the respondents utilized patient complaints, and approximately 40% used the OPPE/FPPE processes in the hospital. Twenty-one percent used targeted reviews of medical records. Five percent reported no method of cognitive assessment.

For assessing procedural and technical skills, almost 80% rely on feedback from other physicians in the practice. One third use OPPE/FPPE assessments, direct observation, or patient complaints. Eleven percent of respondents indicate that they do not assess procedural skills in the aging clinician.

All respondents reported that they do *not* have a mandatory or recommended retirement age, and 80% reported that they have *not* had to dismiss an older physician because of a concern about clinical competence. For those who have dismissed an older physician over clinical competency issues, most incidents were discovered by direct observation, complaints (by nurses, peers, patients, residents, faculty, scribes), or through peer review processes.

Respondents offered numerous additional comments worthy of note. Many commented that overall, this issue is important and requires solutions. Several commented that this issue is difficult, concerning, and can have unfortunate and contentious outcomes if not handled effectively (either through proactive processes or episodically). Respondents

further affirmed the need for authoritative strategies and recommendations for the assessment and management of issues related to the aging clinician. Several indicated that they are working on solutions independently.

Finally, several respondents reaffirmed the value of the aging physician (experience, maturity, quality), and indicated an interest and commitment to effective solutions. Most notably, “Older physicians have years of experience that are very valuable. Their wisdom and experience should be considered an asset, and efforts should be made to enable them to practice at their highest potential.”

### **The Value of the Aging Physician**

In the domains of clinical experience, personal and professional humility, realism and wisdom, aging emergency physicians have much to offer that enriches our practice and provides modeling for younger colleagues.

Better outcomes in clinical practice have been related to previous experiences.<sup>46,47</sup> Experience also enhances the ability to sort high-risk situations from other circumstances in real-time; the acceptance of clinical intuition and clinical ambiguity; and the development of effective coping strategies for clinical mistakes and diagnostic misses. Experience provides knowledge of the most meaningful communication styles for patients, colleagues and learners, as well as the ability to create calm amidst chaos.

A long career provides the opportunity to learn how to deal with an unrealistic impression of self-perfection or perfection in others. The limits of medical knowledge are revealed often and by many; seasoned emergency clinicians have learned when to accept criticism or advice, and when to ignore it. With age, empathy is developed through the personal experiences of pain and loss, and physicians become better at forgiving themselves as well as others.<sup>48</sup>

Aging physicians have developed a more realistic picture of the practice environment. They are better able to recognize which obstacles to seamless daily practice can be overcome, and which must be stepped around; which administrative battles are worth fighting, and which cannot be won. Longevity in practice develops a realistic impression of the strengths and weaknesses of the care team and practice environment, more accurate expectations of responsible practice among all colleagues, and unobtrusive methods to help the team and colleagues ensure the best clinical performance and patient care.<sup>49</sup>

The outcome of longevity in practice is the accumulation of knowledge, insight, and reasoned action based on what has been learned from experience. Such wisdom allows the seeing of patients and not just cases; to practice art as well as science in medicine; to see deeper meaning in personal and professional experiences; and to use self-reflection to grow as a clinician and person.<sup>48</sup>

Understanding and appreciating the unique aspects of aging in emergency medicine is bound to enhance the specialty. Developing creative accommodations for aging physicians may be difficult while meeting the demands of a busy emergency practice, but providing them with unique opportunities (ie, functioning as triage doctor, bedside educator, senior mentor) that tap into their greatest strengths could provide significant value for departments, to preserve, disseminate and reward wisdom.

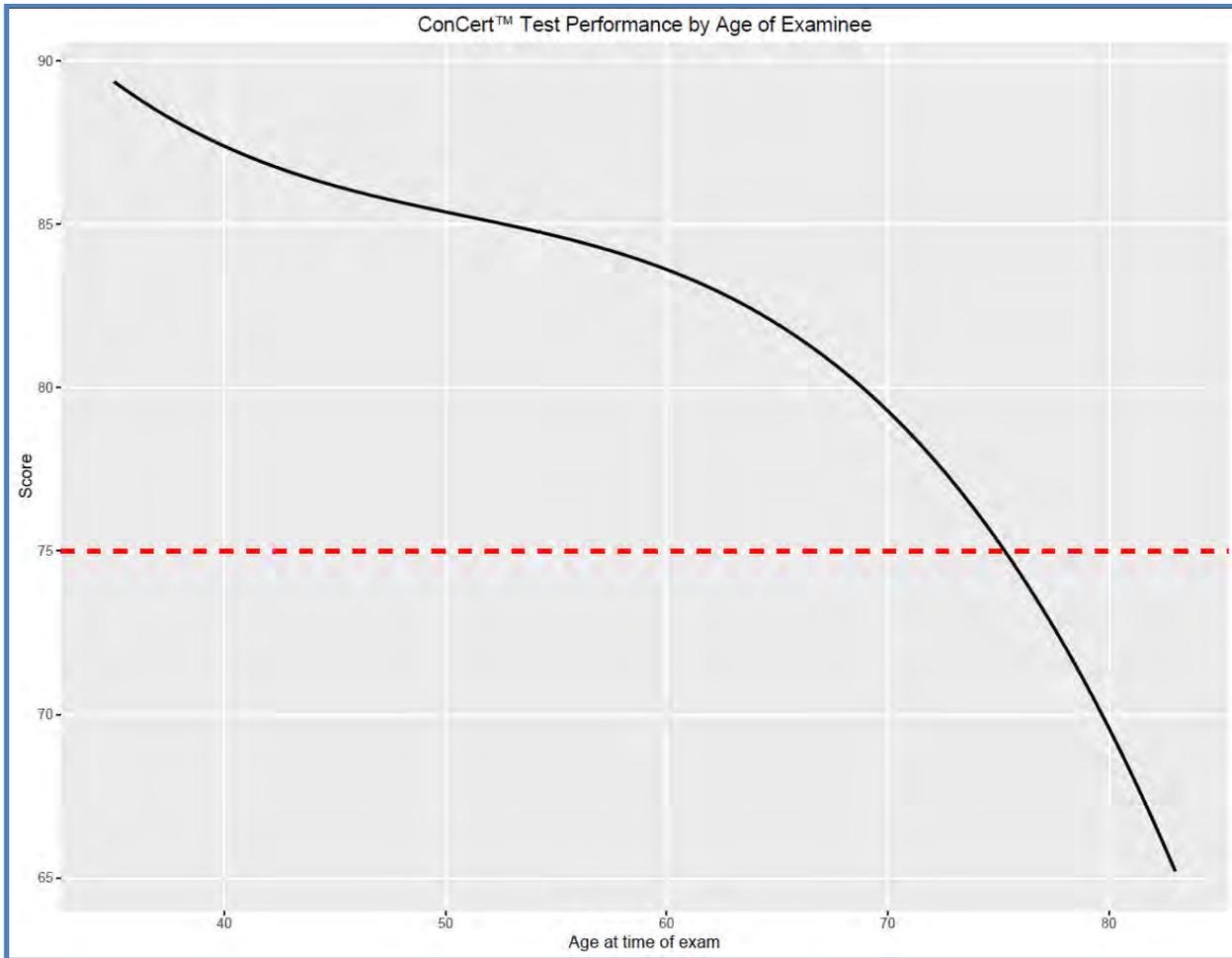
### **Summary of Recommendations and Conclusions**

Physicians face challenges to their practice as they age. These challenges are not just cognitive, but also procedural, physical, and technologic. Aging physicians must integrate new medical science, learn new procedures, and integrate the use of new technology into their practice. The specialty of emergency medicine has a vested interest in prolonging the careers of its physicians, who should have some choice over when they end their medical practice. Currently, however, aging physicians who are unfit to practice are largely identified by observation and the reporting of incidents by colleagues, healthcare team members, and patients. For more than 100 years, the public has relied on the medical profession to regulate itself. As such, we cannot rely on adverse outcomes and must proactively help physicians identify skills that deteriorate, while simultaneously providing feasible accommodations and support to maximize our collective career longevity.

Ongoing professional practice evaluation (OPPE) should be used to monitor the care provided by all providers, not just the aging physician. ACEP and ABEM should work together to develop a standardized process to monitor providers in multiple domains (such as cognitive, procedural, task switching, productivity, etc.). These assessments

should be both formative and summative to assist in individualizing the development needs for those assessed. ACEP and ABEM should also develop or identify resources to help those physicians who are not meeting the specialty's standards. These resources include suggestions for accommodations for the practice of aging physicians. Ceasing the practice of medicine should not be the only option for those who wish to continue their career despite mental and physical limitations.

Figure 1. ConCert Performance Prediction Curve



This performance prediction curve is based on the scores of over 26,000 ConCert test-takers since 2004. ©2016 American Board of Emergency Medicine. Used with permission.

Table 1: Generalizations for Each Generation

**Career Goal**

- Traditionalist: Build a legacy.
- Baby Boomers: Build a stellar career.
- Generation Xers: Build a portable career.
- Millennials: Build parallel careers.

**ClashPoint around Balance**

- Traditionalist: Support me in shifting the balance.
- Baby Boomers: Help me balance everyone else and find meaning myself.
- Generation Xers: Give me balance now, not when I'm 65.
- Millennials: Work isn't everything; flexibility to balance my activities is more important

**ClashPoint around Feedback**

- Traditionalists (Born 1900-1945): No news is good news.
- Baby Boomers (Born 1946-1964): Once a year, with lots of documentation.
- Generation Xers (Born 1965-1980): Sorry to interrupt, but how am I doing?
- Millennials (Born 1981-1999): Feedback whenever I want it at the push of a button.

Source: Lancaster, Lynne C, and David Stillman. *When Generations Collide: Who They Are, Why They Clash, How to Solve the Generational Puzzle at Work*. New York: HarperCollins, 2002. Print.

**Table 2**  
**The ACEP Aging Physician Task Force Survey, May 2017, n=146**

Domain	# of Respondents	Responses
<b>1. Credentialing frequency</b>	146	<ul style="list-style-type: none"> <li>• 56% (82) have presented a physician over the age of 65 to a credentialing body</li> <li>• 44% (36) have presented a physician over the age of 70</li> <li>• 10% (8) have presented a physician over the age of 75</li> </ul>
<b>2. Practice accommodations</b>	80	<ul style="list-style-type: none"> <li>• 81% (65) have accommodated aging physicians by <u>reducing night shifts</u>: <ul style="list-style-type: none"> <li>○ 26% (21) with a pay reduction</li> <li>○ 55% (44) with no pay reduction</li> </ul> </li> <li>• 57% (46) have reduced the <u>total number of shifts</u> the older physician works in a month: <ul style="list-style-type: none"> <li>○ 58% (31) included a pay reduction</li> <li>○ 19% (15) included more administrative/teaching time</li> </ul> </li> <li>• 38 respondents noted a variety of additional <u>practice accommodations</u>: <ul style="list-style-type: none"> <li>○ 23% (18): urgent care / fast track only</li> <li>○ 12% (10): shorter shifts</li> <li>○ 7% (6): double covered shifts only</li> <li>○ 5% (4): work only with residents</li> </ul> </li> </ul>
<b>3. Assessment of cognitive skills</b>	76	<p>Respondents were asked how they assess the cognitive skills of an aging physician.</p> <ul style="list-style-type: none"> <li>• 79% (60) rely on feedback from other physicians in the group</li> <li>• 76% (58) rely on feedback from nurses/staff</li> <li>• 68% (52) require ongoing board certification</li> <li>• 55% (42) use Maintenance of Certification</li> <li>• 47% (36) use patient complaints</li> <li>• 39% (30) use OPPE / FPPE processes</li> <li>• 21% (16) use targeted review of medical records</li> <li>• 5% (4) use no method of assessment</li> <li>• Two respondents utilize formal neurocognitive testing.</li> <li>• One noted that their legal team advised no testing unless a formal complaint/concern was raised.</li> </ul>
<b>4. Assessment of procedural and technical skills</b>	75	<ul style="list-style-type: none"> <li>• 79% (59) rely on feedback from other physicians in the practice.</li> <li>• 33% (25) use OPPE / FPPE assessments, direct observation, and patient complaints.</li> <li>• 12% (9) use nursing, scribe, resident, or documentation feedback.</li> <li>• 11% (8) do not assess procedural skills in the aging physician.</li> </ul>
<b>5. Mandatory retirement age</b>	76	<ul style="list-style-type: none"> <li>• 100% of respondents report that they do <i>not</i> have a mandatory or recommended retirement age.</li> </ul>
<b>6. Dismissal</b>	76	<ul style="list-style-type: none"> <li>• 80% (61) of respondents indicated that they have <i>not</i> had to dismiss an older physician because of concern for clinical competence.</li> </ul>

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