Senior Physicians: Addressing Age, Ability and Acumen

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***Editor's Note**: This special theme section evolved from the Rhode Island Medical Society's regional conference on* Senior Physicians: Addressing Age, Ability, and Acumen *held in September 2016. The symposium was arranged by the RIMS Physician Health Program and made possible by an educational grant to RIMS from the Coverys Community Healthcare Foundation.*

Just a year ago the Rhode Island Medical Society (RIMS) and the Physician Health Program (PHP) convened a full-day symposium about senior physicians and their ability to continue to practice. Well over 100 people attended. Four papers in this issue reflect the variety of subjects presented.

Doctors (at any age) who are observed to be forgetful or have other manifestations of cognitive impairment should be referred for medical evaluation and cognitive testing. Mild cognitive impairment or early dementia that would mandate retirement from patient care may be documented.

Current opinion is that routine cognitive screening of all doctors over a certain age is not likely to be useful. Because of the variability of test results in a population of "high achievers" such testing is not likely to be an accurate independent predictor of whether a doctor should continue to practice. Several screening programs have ceased age-based routine cognitive testing. A detailed exploration of this subject will be presented in a paper to be published in a future issue.

Whether doctors are competent to practice is a decision made by the Board of Licensure and these regulatory issues are reviewed in the paper by Dr. McDonald.

The PHP recently evaluated two senior doctors.

Doctor A was referred because of poor prescribing practices. There was no other evidence of cognitive impairment such as forgetfulness, etc. though he made a "poor impression" during an initial interview with a committee. This resulted in his referral to the PHP. He was leading an active and productive life. The question of whether he was providing acceptable, quality care would not be answered by cognitive testing. The appropriate method of evaluation would be an audit of his practice to determine directly the quality of his care and this was arranged.

Doctor B was referred because many observers agreed that his clinical care was substandard. He also was noted to be forgetful. Cognitive testing did not reveal significant abnormalities. Thinking that this doctor may have had very high cognitive function previously and that the current test was part of a "downhill" process, the cognitive testing was repeated two years later and it was marginally improved!

The lesson: if the question is whether a doctor of any age, in the absence of a suspected impairing illness, is competent to practice, the best way to find out is to evaluate the quality of his patient care directly.

If an impairing illness of any type is suspected, that issue should be resolved as a part of the medical and cognitive evaluation before doing a formal practice audit. It is important to note that normal age-related changes may not impair a doctor's ability to practice if they are recognized. Drs. Minter and Besdine review these issues in their paper.

If a practice audit reveals that patient care is not acceptable, a thorough physical and cognitive evaluation should be undertaken to ascertain whether there is a treatable illness as a cause.

Thus, screening of apparently healthy older doctors is best done by directly evaluating the quality of their patient care. Doctors who practice in large groups are more easily evaluated than those who are in solo practice. Whether screening can be limited legally to older doctors is discussed in the article by attorney Chase-Lubitz.

There is, however, no age restriction on planning for retirement – in fact the earlier one thinks about this, the better. See the discussion by Donna Singer.

The symposium generated discussion about what the next step might be. The result is a task force convened by RIMS with representation including hospitals, government, cognitive scientists, FAA examiners, PHP members, lawyers, medical staffs, chief medical officers and others. It was quickly realized that the discussion must address all age groups and the effort really is a "Patient Safety Initiative." Currently this is a work in progress.

The articles published in this special section of the *Rhode Island Medical Journal* offer the reader a good background in these issues and perhaps some insight into one's own attitude and plans for retirement. And we wish you well on that journey.

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