Board Responsibility in the Face of a Coming Tsunami of "Late Career" Physicians

BY TODD SAGIN, M.D., J.D., SAGIN HEALTHCARE CONSULTING

The aging of the general population is certainly not news to anyone who works in healthcare. Indeed, as the health needs of baby boomers become ubiquitous, our hospitals and health systems will find a constant drumbeat for their services.

Key Board Takeaways

The board has two main responsibilities related to the coming tsunami of aging practitioners:

1. To make sure that all "late career" clinicians to which the board grants privileges are competent and not impaired by the health concerns that become more prevalent with age.
2. To adequately undertake "manpower" planning in the face of the daunting demographics. This means ensuring there are plans for medical staff development and working closely with physician leaders on issues of recruitment and retention.

But the trend that brings patients to hospitals' doors may also usher out large numbers of healthcare providers who reach retirement age. Board members will need to pay increasing attention in the years ahead to staffing needs in the face of growing shortages of physicians and nurses. The American Medical Association has estimated that in 2020 nearly 20 percent of active physicians will be over the age of 65; nearly 40 percent will be older than 55. As the economy continues to climb out of the depths of the 2007–2008 recession many physicians will find their retirement portfolios recovering. Add to that an endemic physician "emotional burnout" rate of nearly 50 percent of practicing doctors, hospitals and health systems are likely to see physician retirements in droves over the next decade. Replacements won't be easy to come by either. The graduate medical education pipeline is simply not adequate to replace the aging population of doctors and it is expected there will be a national shortage of at least 100,000 doctors in just a few short years.

Shortages are just one facet of the challenge posed by an aging physician population. Aging affects the physical and mental capabilities of all humans and physicians are not exempt. This is an important reality when significant numbers of physicians are still practicing into their 70s, 80s, and even 90s. While hospitals may be well served by such physicians, there is growing evidence that the ability of doctors to perform competently wanes with age. Some countries have mandatory retirement ages for surgeons and require competency testing of older physicians as they hit certain age benchmarks. While this is true for some professions in the United States (e.g., commercial pilots and FBI agents) it is not the case for physicians. In addition, there is a preponderance of evidence that suggests that physicians have a limited ability to accurately self-assess their abilities. Studies show the worst accuracy in self-assessment among doctors is found in those who are least skilled and most confident of their abilities. Surprisingly, one-third of physicians *do not even have a primary care physician.*

Ensuring Physicians Are Fit to Continue Practicing

The board has two important responsibilities created by the tsunami of aging practitioners. The first is to make sure that all "late career" clinicians to which the board grants privileges are competent and not impaired by the health concerns that become more prevalent with age. Most boards wait until competency problems manifest themselves in an older doctor before they become alerted that a problem exists. Such discovery may come too late to prevent harm to a patient. To avoid this scenario, many medical staffs and hospital boards are deliberating the implementation of an aging policy to which doctors over a specified age (most typically 70) would be subject.[1] Such policies frequently require some type of "fitness for work" physical exam and cognitive screening, which takes place annually or at the time of medical staff reappointment. Other institutions require routine proctoring or focused professional practice evaluation (FPPE) on a periodic basis once a physician reaches a specified age. Where such examinations or competency monitoring suggest a possible problem, there are several formal programs situated around the country that perform intensive assessments of older practitioners (e.g., the LifeGuard program in Pennsylvania, PACE program in Southern California, and CPEP program in Colorado and North Carolina).

Boards that push for the adoption of an aging policy sometimes find significant pushback from the older population of practitioners on the medical staff. It is natural for older doctors to feel their careers and professional identity threatened by such policies. However, assessment of older practitioners has benefits that go beyond protecting patients. Early identification of health or other issues affecting competency may enhance a practitioner's ability to practice longer. Such assessments can also provide a renewed sense of confidence for the practitioner and his/her colleagues. Issues may be identified that are easily remedied or a physician may be provided with information to evaluate options, including recognition of other professional opportunities. In my experience, many older physicians and their colleagues are relieved to know that age-related disabilities will not be overlooked or ignored.

Planning for Aging Physicians

A second board responsibility is to adequately undertake "manpower" planning in the face of the daunting demographics. Unfortunately, many boards put little effort into medical staff development plans and do not work closely with physician leaders on issues of recruitment and retention. Where recruitment of new practitioners is difficult, some hospitals and health systems will be well served by considering practice accommodations for late career practitioners. Many physicians are willing to practice well past the traditional retirement benchmark of 65, especially if the hospital can provide appropriate assistance. Examples of accommodations to consider include decreasing hours and/or caseloads, allocation of more time with patients through schedule adjustments, accommodations based on physical findings

1 For a sample medical staff aging policy, email Dr. Sagin at tsagin@saginhealthcare.com.

(e.g., use of an amplified stethoscope), decrease or limitation in scope of practice, and ongoing education with respect to electronic health records documentation. Some healthcare organizations encourage retention of older physicians by adjusting on-call requirements, waiving medical staff dues, or assisting with scribes. Any of these accommodations can be controversial, so boards must discuss them carefully with medical staff leaders before any are adopted and implemented.

The flip side to the retention of older practitioners is the recruitment of new, younger practitioners. While many hospitals and health systems have greatly increased their efforts at recruitment and retention in recent years, many have not. Board members should insist on being kept informed about medical staff and management efforts to strengthen the onboarding of new doctors and to create a professional community appealing to millennials. The Henry Ford Health System has been a pioneer in such efforts through the adoption of numerous recruitment and engagement strategies for Generation Y. For example, Gen-ERG-Y is a team created by the HFHS Diversity Council for employees born after 1980. Its charge is to leverage multi-generational differences and commonalities to attract and retain talent. Gen-ERG-Y holds meetings, workshops, and events that focus on effective communication among the generations, collaborative work styles, career life cycle, and more.

The board can't simply assume that problems posed by an aging workforce will automatically be addressed by the medical staff and management. Boards should hear regularly from leaders about how they are planning for and responding to the impact of the demographic changes described in this article. Boards must also guard against the possibility that in the face of growing physician shortages, the hospital's standards for competency will be lowered to keep staffing adequate. There are many considerations surrounding physician generational challenges, but with proper board attention our hospitals, professional workforce, and our communities can age safely and well.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. *He can be reached at tsagin@saginhealthcare.com.*