Ann Weinacker, M.D.
Senior Vice Chair of Medicine for Clinical Operations at Stanford University

Ann Weinacker is the Senior Vice Chair of Medicine for Clinical Operations at Stanford University, and is Associate Chief Medical Officer, Patient Care Services at Stanford Health Care (SHC). She is also the Interim Chief Quality Officer at SHC. She served as Chief of Staff from 2011-2014 after serving as Vice Chief of Staff from 2010-2011. Dr. Weinacker has extensive experience in SHC clinical and administrative leadership, in addition to serving since 1999 as a full-time faculty member in the Stanford University School of Medicine. She is currently Professor of Medicine, Division of Pulmonary and Critical Care Medicine and is Associate Director of the Intensive Care Unit. A strong advocate for patient centricity, Dr. Weinacker was appointed in November 2009 to be one of four leaders designated to actively design, guide and implement strategies to improve the patient experience at Stanford, and she continues to serve in that capacity. Her research focus is predicting lung transplant outcomes.

Dr. Weinacker began her career as a nurse and nurse anesthetist before completing her M.D. degree at the University of South Alabama College of Medicine, Mobile, in 1986. Her advanced training includes a pulmonary and critical care fellowship and a cardiovascular postdoctoral research fellowship, completed at the University of California, San Francisco in 1994. She is the winner of numerous national honors, editorial posts. Locally, she received the SHC Board of Hospital Director’s coveted Denise O’Leary Award for Clinical Excellence in 2008.

Evolving Considerations for Late Career Practitioners

Ann Weinacker, M.D.
Professor of Medicine
Stanford University
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Background

- The Medical Staff must protect quality of patient care and ensure the competence of physicians
- The total number of physicians 65 and older more than quadrupled from 1975 to 2013
- 20% of physicians in the US are older than 65

Background

- Age-related declines in cognitive and physical functioning can affect professional performance -- Physicians are not immune
- Studies of older physicians referred to medical boards or regulatory bodies for poor practice show that about 50% have cognitive difficulties
- Multiple studies have shown older physicians are more prone to cognitive impairment, substance abuse, depression, and physiologic decline

Benefit/Risk

- Age has value
  - Age does not *per se* result in a decrease of cognitive function
  - Age and experience can increase important aspects of a physician's practice such as knowledge, compassion, and stress tolerance
- Any policy must balance:
  - Quality patient care
  - Protecting the reputation and self-esteem of the physician

Growing Support

- Similar policies have been adopted by an increasing number of organizations
- California Public Protection and Physician Health, Inc. drafted a lengthy statement in support of such policies in 2015
- The American College of Surgeons released a statement in 2016 in support of evaluating and supporting aging surgeons

AMA Statement 2015

- It is the opinion of the Council on Medical Education that physicians should be allowed to remain in practice as long as patient safety is not endangered and that, if needed, remediation should be a supportive, ongoing and proactive process. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self regulation. Therefore, physicians must develop guidelines/standards for monitoring and assessing both their own and their colleagues' competency. Formal guidelines on the timing and content of testing of competence may be appropriate and may head off a call for mandatory retirement ages or imposition of guidelines by others.

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In Support of LCP Policies

- Many physicians recognize limitations and restrict their own practices, but others do not
  - Anosognosia is common as limitations develop, as is anger in having those limitations pointed out
  - Self-monitoring alone typically is inadequate
- Two studies have shown that physicians are reluctant to report concerns about the competency of one of their peers (only ~50% would do so)
  - One study found that 90% of physicians who would not report assumed that the competency limitations were already known to others

Stanford's Late Career Practitioner Policy

- Requires all medical staff members age ≥75 to undergo peer clinical skills assessment and health screening every two years addressing competence to perform the clinical privileges requested
- There is no cognitive screen in the current policy
- The policy may be applied to practitioners of any age when concerns are raised about their ability to practice competently

Stanford's Late Career Practitioner Policy

- Designed to put the wellbeing of patients above other issues
- Well-structured rigorous peer review is useful in evaluating cognitive, physical and humanistic aspects of physician performance when done in a confidential and compassionate manner

Response to Concerns Identified

- Department/Service and Credentials Committee decide on further evaluation
  - For example, cognitive screen, fitness for duty evaluation, referral to WellBeing, etc.
- Goal is to be supportive, not restrictive
- Restriction of privileges must be considered as last resort

Application of Policy

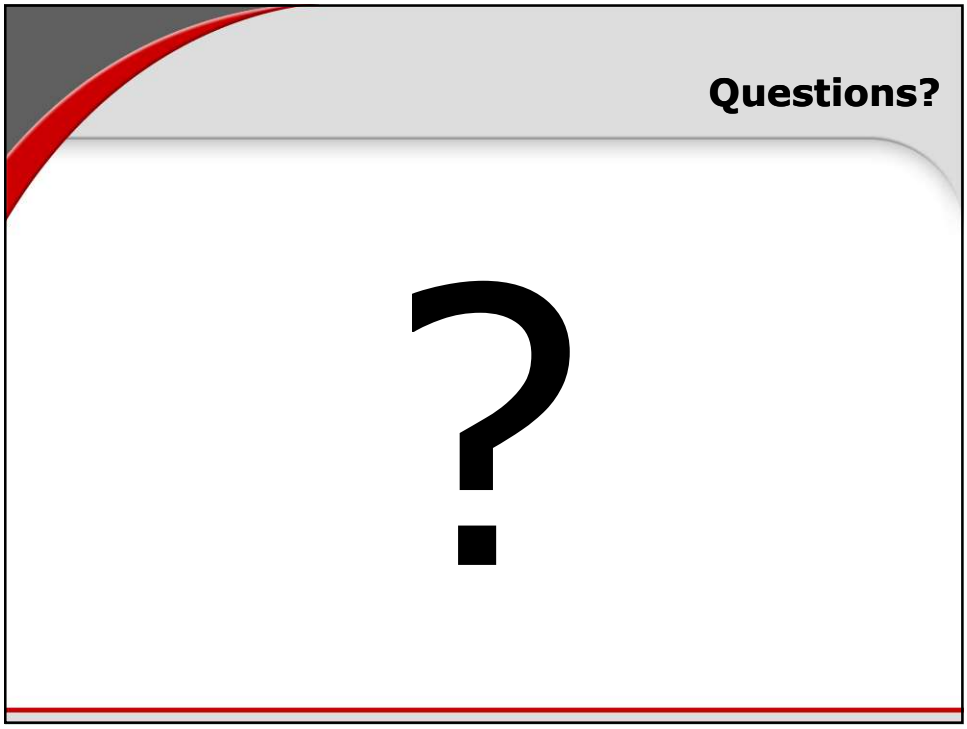
- Since implementation almost 5 years ago, about 60 physicians screened under the policy
  - Over half have been screened more than once
- Three physicians identified for further testing with a cognitive screen
- One physician <75 has been through screen "for cause"
- 10-15% of late career physicians chose to retire without going through the screening

Lessons Learned

- Process is achievable and sustainable, even with a medical staff comprised of both community and faculty physician members
- Allowed the Medical Staff to represent another element of competency and quality assurance
- Significantly increased visibility of issue over past few years
- This is important, but is neither easy nor cheap

Key Questions

- What age?
- How frequent?
- Which type of assessment or screening?
- How to integrate with existing reappointment and credentialing processes?
- Who pays?
- Is the policy rationally related to patient care?


Questions?
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