STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 · Olympia Washington 98504-7852

DENTAL QUALITY ASSURANCE COMMISSION
DENTAL CONTINUING COMPETENCY COMMITTEE
WEBINAR MEETING AGENDA - AMENDED

DATE: **Thursday, August 16, 2018**

TIME: **12:00 p.m.**

LOCATION: **Webinar**

CONTACT: **Jennifer Santiago, Health Services Consultant 4**
Phone: (360) 236-4893
Fax: (360) 236-2901

Times and Order: The meeting will commence at 12:00 p.m. on August 16, 2018 and continue until agenda items are completed. Public comment will be taken during the committee meeting. This agenda is subject to change.

Accessibility: This meeting is accessible to persons with disabilities. Special aids and services can be made available upon request. If you need assistance with special needs and services, you may leave a message with that request at 1-800-525-0127. If calling from outside Washington State, dial 360-236-4052. TDD may also be accessed by calling the TDD relay service at 1-800-833-6388. If you need assistance due to a speech disability, Speech-to-Speech provides human voices for people with difficulty being understood. The Washington Speech-to-Speech toll free access number is 1-877-833-6341. If you wish to receive general information about this meeting, please call the program at 360-236-4893.

OPEN SESSION - 12:00 p.m.

1. **CALL TO ORDER –** Dr. Richman, Committee Chairperson

   1.1. Roll call of attendees.
   1.2. Approval of agenda.
   1.3. Approval of the May 30, 2018 meeting minutes.

2. **DENTIST CONTINUING COMPETENCY**

   2.1. The committee will review past meeting minutes related to continuing competency discussions.
   2.2. Washington Physician Health Program – Dr. Bundy

2.3. The committee will discuss a proposal by Dr. Marsh and Dr. Richman.
2.4. The committee will discuss the Medical Quality Assurance Commission's Practitioner Competence guideline.
2.5. The committee will receive an article "Study Finds Physician Age Linked to Mortality Risk" and Assessing Aging Physicians"

3. FUTURE BUSINESS

The committee will determine
3.1. Information needed for the next committee meeting.
3.2. Specialty Advertising Rule WAC 246-817-420

- National Commission on Recognition of Dental Specialties and Certifying Boards
  - Letter to commission dated June 29, 2018.
  - Policy and Procedure Manual.
  - May 9-10, 2018 meeting minutes.

4. ADJOURN

Webinar Instructions:

To participate in the webinar meeting, contact Jennifer Santiago at jennifer.santiago@doh.wa.gov or 360-236-4893 for the approved webinar link.

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DENTAL QUALITY ASSURANCE COMMISSION
DENTAL CONTINUING COMPETENCY COMMITTEE
CONFERENCE CALL MEETING MINUTES

Wednesday, May 30, 2018

MEMBERS PRESENT
Julia Richman, DDS, Committee Chair
Ronald Marsh, DDS, Committee Vice-Chair
Lyle McClellan, DDS

MEMBERS ABSENT
David Carsten, DDS
John Carbery, DMD

STAFF PRESENT
Jennifer Santiago, Program Manager
Trina Crawford, Executive Director
Heather Carter, Assistant Attorney General

OTHERS PRESENT
Emily Lovell, Washington State Dental Association (WSDA)
Mellani McAleenan, WSDA
Bryan Edgar, DDS, WSDA
Keyvan Sohrabi, DDS, WSDA
Keith Collins, DMD, WSDA
Patrick Taylor, DDS, American Association of Endodontists (AAE)

OPEN SESSION

1. **CALL TO ORDER –** The meeting was called to order at 12:04 p.m.
   1.1. Attendees were introduced.
   1.2. The committee approved the agenda.
   1.3. The committee approved the April 9, 2018 minutes as presented.

2. **SPECIALTY ADVERTISING RULE**
   2.1. The committee discussed stakeholder comments for WAC 246-817-420.
   - Heather Carter provided information related to Indiana and California court cases. Additionally, there are other litigation in other states.
     - Bingham vs. Hamilton case, the courts found that it was unconstitutional to require one year of Commission on Dental Accreditation (CODA) education. There was no evidence that proved one year of CODA education was necessary.

  - A current case in Indiana is scheduled for trial in January 2019. Indiana asked the court to stay the trial by changing their rule language to two years of CODA education to be recognized as a specialist. The court denied the request. A two-year requirement will be tested in this court.
  - Ms. Carter recommends the committee holds rule modifications until after the Indiana decision is made.
- Dr. Richman indicated she was unsure why California would have imposed a one-year requirement as all specialty residencies are at least two years in length.
- Dr. Marsh asked what the American Dental Association (ADA) has done. Additional research on the ADA's Dental Specialty Commission is needed. The specialty commission has met once but just to formalize the organization. They have another meeting scheduled in July.
- Dr. McClellan indicated that a previous option before the dental commission was to repeal the rule. What is the benefit of this rule? Discipline would not change if there is patient harm.
- Dr. Edgar indicated the rule provides the public with an understanding of what a specialist is.
- Dr. Richman agreed public knowledge is needed to know the difference from a general dentist and a specialist.
- The committee discussed if they should wait for ADA and court case decisions before continuing rule modifications.
- Other states do have advertising and disclaimer requirements related to specialty training.
- Any dentist can state the organizations to which they belong. General dentists can join specialty organizations without being a specialist or being board certified as a specialist.
- Specialties are evolving. Rules should accommodate new specialties.
- Dr. Edgar expressed strong educational standards and formal education are needed.
- Dr. Collins indicated general advertising should allow for practitioners to publish education and areas of study they have completed.
- Dr. Sohrabi indicated the law should not be vague.
- Dr. Richman indicated that being a specialist is different than limiting your practice area.
- Specialty is more than advertising
- What is the benefit for specialists?
- Specialty is not about the scope of practice but patients' misunderstanding of what a specialist is.
- Dentists educate the public through advertising and referrals.
- The statute provides the authority to discipline for unprofessional conduct for false or misleading advertising.
- One rule indicates a practitioner can state they belong to an organization and another rule limits specialties to nine ADA approved specialties.
- Disclaimers are a less restrictive option.

2.2. The committee received articles from the ADA related to the Dental Specialty Commission and the ADA Principles of Ethics and Code of Professional Conduct.
2.3. The committee receive copies of other states' rules related to specialty representation or advertising.
2.4. The WSDA recommends language similar to Ohio. The committee determined to hold rule modifications until August/September.

3. FUTURE BUSINESS

3.1. The committee determined to put rule modifications on hold until the fall. The committee requested a summer webinar meeting and an in-person meeting in the fall.
3.2. Ms. Santiago reported the next commission newsletter will have multiple articles related to new the continuing education rule. Additionally, messaging will be added to renewal and license notices. Frequently asked questions were previously reviewed and will be posted on the web when the rule is finalized. Information will be provided at the Pacific Northwest Dental Conference. The jurisprudence examination committee will update the continuing education questions on the jurisprudence examination.
3.3. Next meeting will focus on continuing competency.

4. ADJOURN

The meeting was adjourned at 12:46 p.m.

Submitted By:	Committee Approval By:
_____	_____
Jennifer Santiago, Program Manager	Julia Richman, DDS, Committee Chair

Past committee minutes related to continuing competency

April 19. 2017

CONTINUING COMPETENCY

The committee discussed comments received:

- The committee received a copy of an article Medical Quality Assurance Commission published from Washington Physician's Health Program regarding Cognitive Performance.
- Dr. Richman expressed the committee should be mindful of anti-discrimination laws.
- Heather Carter, AAG indicated there are protected classes in the American Disabilities Act. Evaluating is difficult. If there is a concern of someone's ability to practice, then the disciplinary process should be used to evaluate.
- Dr. Marsh presented a draft document proposing a continuing competency program. The committee would like to place this proposal on hold for a future meeting. This is a difficult topic and a good starting point.

The committee did not discuss a survey.

The committee agreed to complete the CE rule modifications then work on continuing competency.

March 17, 2017

DENTIST CONTINUING COMPETENCY

The committee received and discussed stakeholder comments regarding continuing competency.

- Dr. Richman indicated the committee should consider anti-discrimination laws when addressing physical dexterity and physical ability.
- Beth Cole provided an email discussing the WREB continuing competency program. This was an in-office audit for dental competency, coupled with an in-office self-evaluation.
- Dr. Carsten provided research on the efficacy of online courses. Online courses are better if they are more engaging and include a follow-up examination. Online courses are more popular with millennials. All courses need to be cognitively difficult and engaging. Dr. Carsten agrees with accepting one-half credit for each hour of online study.
- The committee asked Ms. Lovell if there can be a quiz at the end of the PNDC courses. Ms. Lovell responded that the Washington State Dental Association (WSDA) provides a certificate at the end of the course, but they must provide a verification code proving they were in attendance to receive the certificate. Ms. Lovell will talk with PNDC staff about end of course quizzes.
- Dr. Marsh indicated that if Washington requires quizzes at the end of all CE, nationwide CE would no longer be valid.
- Could the commission model continuing competency after board re-certification requirements?

The committee discussed whether a survey to stakeholders is needed. The committee will discuss this topic more at the next meeting.

The committee discussed continuing competency methods.

- Create a system similar to board recertification.
- Require continuing education with examinations.
- Create more difficult continuing education requirements in rule.

December 5, 2016

DENTIST CONTINUING COMPETENCY

The committee discussed using an examination process such as the jurisprudence examination as a measurement of continuing competency.

- Dr. Carsten indicated concern regarding measuring competency by an online examination. Competency includes physical, cognitive and psychological factors.
- Specialists take a continuing competency examination every ten years. Should the commission require the dental continuing competency examination more often?

Dr. Bryan will report the committee's discussion to the commission at the upcoming meeting.

November 3, 2016

FUTURE BUSINESS

- Will discuss continuing competency.
  - Dentist continuing competency methods.
    - Royal College of Dental Surgeons of Ontario Practice Enhancement Tool (PET)
    - Specialty board certification and re-certifications
    - Other
  - Measuring continuing competency.
    - Defining "standards of dental practice"
    - Methods of measurement
    - Other
  - A survey to provide to stakeholder regarding regulation of dentist continuing competency.

WASHINGTON STATE CONTINUING DENTAL COMPETENCE CERTIFICATION

2018 DRAFT PROPOSAL

THIS IS A WORKING DOCUMENT

In order to elevate the standard of dental care for the citizens of Washington State and encourage the delivery of superior dental care, a program of continuing competence is proposed for action. The proposed program supplements individual practitioner's continuous professional self evaluation that is ongoing. This program will protect the public and enhance practitioner skill.

It is firmly recognized that a 10 year cycle of professional re-certification is the most effective. By giving practitioners the option to renew certification at year 8, 9, and 10 it is recognized that the program will have maximum effectiveness and efficiency. Re-certification will be based off of the date of graduation from dental school for each practitioner. The implementation of the program with initiation dates and grandfather clauses will be negotiated.

THE PROPOSED PROGRAM RECOGNIZES THAT THE FOUR KEY ELEMENTS OF COMPETENCE MUST BE ADDRESSED.
1. Physical
2. Cognitive
3 .Psychological
4. Educational Updating

IN ORDER TO ESTABLISH THE STATUS OF EACH APPLICANT FOUR AREAS OF VERIFICATION MUST BE CONFIRMED.

1. EVIDENCE OF PROFESSIONAL STANDING

2. EVIDENCE OF LIFELONG LEARNING

3. EVIDENCE OF COGNITIVE EXPERTISE

4. EVIDENCE OF PERFORMANCE OF PRACTICE

THIS PROGRAM WILL BE:

1. RELAVENT
2. FAIR
3. AFFORDABLE IN BOTH TIME AND MONEY

1. EVIDENCE OF PROFESSIONAL STANDING

Each applicant must be in possession of an unrestricted license to practice dentistry in the State of Washington and forward a valid license for review.

Each applicant must submit to a Criminal Background Check by the Washington State Patrol

Each applicant must submit to a Disciplinary Check through the NPDB

2. EVIDENCE OF LIFELONG LEARNING

Each applicant is required to complete 126 hours of ADA CERP Continuing Education in the three years prior to apply for certification. These hours are NOT in addition to the required 63 hours required for routine licensing. The applying dentist will attest to the training at the time of application and will be subject to a random audit program.

3. EVIDENCE OF COGNITIVE EXPERTISE

Each applicant must take and pass the Washington State Jurisprudence exam within one year of application for recertification.

Each applicant will be required to take and pass a DENTAL written examination(computer based) within one year of applying for recertification. A sample exam to be used as a template will be obtained from the ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO for use. This exam will be updated every 5 years by FACULTY VOLUNTEERS of the University of Washington School of Dentistry.

Practitioners may take the re-take the exam a maximum of three times IN A YEAR before retraining is required through DQAC. The exam will be administered by the PEARSON testing Agency and will consist of 100-150 multiple choice questions. Historically these type of exams have had significantly high passing rates, but some practitioners will fail.

4. EVIDENCE OF PERFORMANCE OF PRACTICE

Each applicant will submit his/her office for evaluation by any Washington State Licensed Dentist whose office is not in the same Post Office Zip Code. Evaluations will only consist of facility, equipment, and training record checklists. CHECKLISTS WILL BE DEVELOPED TO COVER THESE AREAS. These forms will be forwarded by mail to the DOH/DQAC. Deficiencies must be corrected before mailing. All checklists will be signed by the independent evaluating dentists along with their Washington State license number and verified office ZIP code.

Applicants will be charged an administrative fee to cover the costs of the program. It would be anticipated that the average practitioner will re-certify 3 times in the course of a dental career, wth the first certification coming 10 years after graduation from dental school.

In place of this program, applicants may substitute verification of Board Certification by any of the 9 currently ADA approved Specialties. Applicants who fail to complete the certification process in the allotted time, can have their dental licenses temporarily suspended by DQAC. A DETAILED RE-INSTATEMENT PROTOCOL WILL NEED TO BE DEVELOPED.

ALL COMPETENCE PROGRAM CERTIFICATIONS will be confidential with access by the public within legal parameters.

Respectfully submitted;

Ron Marsh DDS
Washington State Dental Quality Assurance Commission

Continuing Competence Program Pilot Test Proposal

Julia Richman DDS MSD MPH

August 10, 2018

Continuing competence of healthcare professionals is not a new concept, however it has been brought to national and international attention recently. A number of reasons exist for this. Quality metrics for care are becoming ever more prominent as EHR's have become a new standard, making it easier to mine patient encounter data for outcomes as part of a quality assessment process. Health insurance carriers and CMS require healthcare professionals to meet a certain standard in order to remain in network and receive payment for claims. The media may report on healthcare that is found to be substandard, especially if such care results in the injury or death(s) of patients. Patients may be less willing to allow health care professionals to deliver care in a paternalistic style, instead demanding patient or family centered care, with the patient and family being active participants in their own health care instead of passive recipients of said care whose attitude is "whatever you think, Doc." It has been asserted that traditional CE models are likely to be ineffective in ensuring competence and preventing patient harm.[1] What is unclear is which model of continuing competence program will be most effective at promoting and ensuring competent practitioners.

US state and Canadian provincial boards and commissions regulating health care have a delicate balancing act. They must balance at one end the very real risk of incompetent providers being allowed virtually free reign to practice in a way that not only is not beneficial to the patient but may actually cause harm, with the opposite extreme of being draconian through introducing regulations that harm responsible practitioners through additional cost, unnecessary oversight, and bureaucratic hassle. They must consider measures that are 1) fair, 2) that will reduce the risk of harm to the public, and that will be 3) cost effective both for the taxpayers and for the licensed health care professional. These measures must not be discriminatory, as strong federal laws exist that protect individuals over age 40 (the Age Discrimination Act of 1976[2]), those who are pregnant (the Pregnancy Discrimination Act of 1978[3]), and those who meet the ADA definition as having a disability, which is:

> *a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment.*[4]

Although the first two Acts are intended at protecting employees, it is very conceivable that the courts could view dental licensing / renewal of licensure to be in the same category as employment since many dentists are self-employed and rely on state licensure to practice their trade. ADA Title II includes state and local regulatory and licensing agencies. Clearly, the definition of disability set by the ADA establishes a very wide criterion as to whom can be considered as having a disability, and could be seen as including both aging and pregnant individuals as well.

It is necessary to note that an anti-discrimination case against the Louisiana State Supreme Court regarding the state bar admissions process was successfully litigated by the US Department of Justice and was settled in 2014.

> *The department's investigation found that during the Louisiana bar admissions process licensing entities based recommendations about bar admission on mental health diagnosis and treatment rather than conduct that would warrant denial of admission to the bar.*
>
> *The settlement agreement ensures the right of qualified bar applicants with mental health disabilities to have equal access to the legal profession as required by the Americans with Disabilities Act (ADA). It prohibits the court from asking unnecessary and intrusive questions about bar applicants' mental health diagnosis or treatment. It also requires the court to refrain from imposing unnecessary and burdensome conditions on bar applicants with mental health disabilities, such as requests for medical records, compulsory medical examinations or onerous monitoring and reporting requirements.*
>
> *Title II of the ADA prohibits public entities, including licensing entities, from imposing unnecessary eligibility criteria that tend to screen out individuals with disabilities, or imposing unnecessary burdens on individuals with disabilities that are not imposed on others.*
>
> *The department found that diagnosis and treatment, without problematic conduct, did not effectively predict future misconduct as an attorney and did not justify restrictions on admission.* [5] *(emphasis mine)*

There are very relevant concerns as to how the normal aging process affects healthcare professionals, especially those such as dentists who rely on excellent eyesight, motor skills, hand-eye coordination, and neurological function in order to practice with skill and competence.[6] This is also a concern with dentists who, through no fault of their own, develop a medical condition that may temporarily or permanently affect their ability to practice without undue risk of inadvertent patient harm. However, this must be balanced with the significant risk of being unable to defend regulatory practices as being non-discriminatory in ADA-related litigation. It also must be balanced with basic fairness and with avoidance of regulations with the unintended consequence of incentivizing dentists to cover up medical conditions, or to not seek necessary medical care due to fears of having to report to the state dental commission.

Any continuing competence proposal must be evidence based, non-punitive, fair, non-discriminatory, and cost-effective. It must be reasonable and not onerous to the practitioner who has not given the state dental commission cause to question their fitness or competence. To this end the following questions need to be answered:

1) How does the commission assess continuing competence at entry level, mid-career, and pre-retirement? Should it be assessed differently or should the bar be set the same? Should initial licensure requirements count for an individual and if so for how long? What should the frequency be for assessment? It appears that a 10 year model is effective based on speciality board recertification and was proposed by Dr Marsh.

2) How does the commission assess competence of specialists vs generalists? It would be unfair and unwise in the extreme to expect an oral surgeon or a dental radiologist to demonstrate mid-career competence in, for example, scaling and root planing. Board-certified specialists are required to recertify and demonstrate continued competence in some form on a regular (often every 10 year) basis. That said, since Washington per statute does not have specialty dental license, licensed dentists in washington are essentially considered equivalent with regards to licensure. Should national board certification and recertification be considered as substantially equivalent to a continued competency process, or make up a portion of any process?

3) How does the commission avoid valid claims or litigation regarding discrimination based on age, pregnancy, or protected disability and yet attempt to mitigate harm to a patient before it occurs as a result of practitioners who cannot practice safely due to physical or mental impairment?

4) How does the commission proceed in a manner that is fair amongst licensed dentists and treats them equally after due consideration is given to board certification?

5) How does the commission proceed in a manner that is evidence-based, and that results in a process that is significantly more effective than traditional CE requirements in ensuring competence?

6) How does the commission proceed in a manner that is cost effective and avoids undue restriction of trade or imposing excessive costs or burden on practitioners who have not had any disciplinary action?

7) How does the commission proceed in a manner that will not result in the unintended consequence that practitioners who are struggling are disincentivized to seek help and thus fail to obtain the help they need until after causing patient harm?

8) How does the commission proceed in a manner that rewards dentists who do activities such as: clinical instruction, hands-on CE, service in organized dentistry, publishing in peer-reviewed journals, or regular attendance at rigorous study clubs? How does the commission promote self-driven quality improvement

practices such as chart audits for rigorous quality assessment? All of these are likely to have a benefit, whether measurable or not, in continued competence.

Continuing competence pilot project proposal:

1. Pilot test on individuals who are being served with SOA/STID
    a. Continuing competence track will be added to matrix as an optional sanction package
    b. At the panel's discretion, the respondent will be offered the option of going through the continued competence program instead of a traditional sanction. The requirements of the program will include:
        i. Regular (monthly or at most bimonthly) study club meetings or one-on-one meetings for study and or mentorship between dentists. Meetings will need to be documented by one other licensed dentist who is not under investigation or in compliance, and who will attest to the board that the study club occurred for at least 1 hour and included literature review and case reports. Documentation of the literature discussed and cases reviewed will be necessary. This will run for a defined period of time, possibly 6 months minimum to a year or more maximum.
        ii. Self assessment. The respondent will select 5 cases to submit to the panel and write a one page self assessment for each case
        iii. CE. The respondent will read 5 articles relevant to his or her practice and complete the Critical Evaluation of Journal Article for each one to demonstrate his or her understanding of the article.
        iv. JP exam
        v. The respondent who completes the continued competence pilot project will be asked to give a confidential feedback survey. Survey feedback will be anonymized and will not be part of the respondent's file.
        vi. Successful completion of the continued competence pilot will be noted on the respondent's record.
        vii. Site visit could be considered for certain cases as per Dr Marsh's proposal but would pose logistical challenges that would need to be addressed.
        viii. Peer review may also be considered, if appropriate reviewing dentists could be identified and were willing to take part.
2. Phase II: survey results, stakeholder comment. Continued competency program to be developed. Possible elements include: peer review as an option, board certification and recertification, JP exam, literature review, small group or one-on-one mentoring, self assessment, portfolio submission, or others. The above questions would need to be resolved. It would need to be determined if there would be a different track for individuals with disciplinary history vs without and for individuals with serious vs relatively minor disciplinary history. Legal review would be essential as would extensive stakeholder input and hopefully buy-in.

3. Phase III: Implementation of continued competence program. Appropriate administrative costs would have to be quantified and who (ie the commission or the dentist) would be responsible for the costs would need to be determined. Logistical challenges would have to be addressed. It would be necessary to do a reassessment after the program was started to determine if changes were necessary to ensure a robust, fair, and successful program. There should be a means of assessment of the program over a 1, 3, 5, and 10 year timeframes.

Respectfully submitted,

Julia Richman, DDS MSD MPH

References

1. Dodge et al. 2012. Continued Competency Assessment: Its history and role in health professions. JACD 79(3) pp5-11.
2. EEOC. Facts about Age Discrimination. https://www.eeoc.gov/eeoc/publications/age.cfm Accessed 8/9/2018
3. EEOC. Pregnancy Discrimination. https://www.eeoc.gov/eeoc/publications/fs-preg.cfm Accessed 8/9/2018
4. Americans with Disabilities Act, 1990, definition of “disability”.
5. DOJ settlement with LA Supreme Court, August 14, 2014, *https://www.justice.gov/opa/pr/department-justice-reaches-agreement-louisiana-supreme-court-protect-bar-candidates*
6. Dellinger et al. 2017. The Aging Physician and the Medical Profession: A Review. JAMA Surg 152(10) 967-971

State of Washington
Medical Quality Assurance Commission

Guideline

Title:	Practitioner Competence	GUI2018-02
References:	AMA Code of Ethics 9.3.1 Physician Health & Wellness; RCW 18.71.050; RCW 18.130.170	
Contact:	Medical Commission Licensing Unit	
Phone:	(360) 236-2750	E-mail: medical.commission@doh.wa.gov
Effective Date:	April 13, 2018	
Approved By:	Warren Howe, MD, Chair (signature on file)	

Assessment Framework

The ongoing assessment of competent medical practice is a life-long process and begins with the practitioner. The Medical Commission recommends practitioners participate in regular health evaluations as part of their professional responsibility. Such evaluations should include physical, dexterity, mental, and cognitive components. In most situations, feedback from external sources such as patients and peers are beneficial tools for self-assessment and monitoring.

Practitioners should commence these evaluations starting with their first certification cycle (ABMS for physicians or NCCPA for physician assistants) following initial certification. If a practitioner does not pursue certification, the practitioner should initiate an evaluation after completing a residency or other postgraduate training. These initial evaluations, beginning at around age 30 for most, will serve as a baseline metric for future comparison during the practitioner's career.

Practitioners may find it convenient to do these assessments in conjunction with their recertification process, which generally occurs every seven to ten years. The Commission generally recommends practitioners reduce the interval between these evaluations as they age to better detect evolving limitations. Practitioners with chronic illnesses, lacking specific senses, or known disabilities should consider increasing the frequency of their assessments regardless of age to better enable monitoring of status changes.

Age	Recommended Frequency
30-55	Every 7-10 years, appropriate health assessment
55-65	Every 5 years, appropriate health assessment

65-75	Every 2 years, appropriate health assessment
75+	Every year, appropriate health assessment

Practice Modification

Practitioners will commonly encounter a point in their practice when their skills decline. Such decline might be due to a physical limitation, such as a hearing loss, or a disease impacting cognitive function. In many cases such decline will be associated with the normal aging process. It is important for both the practitioner and those in the practitioner's practice setting to recognize these changes and adapt to them for the safety of the practitioner and the patient. The Medical Commission recommends practitioners consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. Practitioners may consider practice modifications such as reducing or eliminating overnight call schedules, mandated call recovery periods, part time practice, reducing office hours, and eliminating certain strenuous procedures.

Practitioners should also be aware of the effects of burnout, a psychological response to chronic work-related stress. Burnout may be experienced as irritability, low frustration tolerance, exasperation, fatigue, dreading work, callousness toward patients, interpersonal conflicts, diminished social functioning and existential doubts about career or life choices. Once identified, the Medical Commission recommends that practitioners take active measures to address burnout. This may involve identifying sources of burnout in the practice environment and working collaboratively with leadership to resolve the issues. In other cases, practice modifications, as outlined above, may be required to alleviate burnout and the health risks it poses for both practitioners and patients.

Conclusion

The Commission encourages practitioners to use regular health evaluations to gauge their abilities to practice over the course of their careers. Such evaluations should identify aspects of practitioners' practice that may be at risk and what duties the practitioners might consider altering for the safety of the practitioner and the patient. The Washington Physicians Health Program can provide further evaluation and assistance to practitioners when there is concern that a health condition may threaten safe practice.

Conversations regarding health-related declines in practitioner competence and potential modifications should ideally involve the support system of the practitioner to include family, clinical partners, peers, and employment settings. With appropriate consideration of current health and ability status, practitioners can usually modify their practices, as necessary, to extend fruitful and satisfying careers regardless of age. The Commission strongly supports all medical practitioners proactively evaluating their competence on a regular, career-long basis and utilizing the results of such evaluations to help maintain ongoing safe and successful practice.

Read the article here: http://jmr.fsmb.org/wp-content/uploads/2017,/04/StandardAssessment_JMR-102_4_FINAL-2.pdf.

Study Finds Physician Age Linked to Mortality Risk

An article by John Commins in the May 18, 2017, *HealthLeadersMedia* reports on a study published in BMJ about research at Harvard that found mortality rates of 10.8% among patients treated by hospitalists 40 and younger compared to rates of 12.1% among patients treated by hospitalists 60 and older. Lead author Anupam B. Jena, MD told Commins that a goal of the research is to help resolve the ongoing debate about what should be required of physicians in the way of continuing professional development as they age and go further out from residency.

See more: http://www.healthleadersmedia.com/physician-leaders/physician-age-linked-clinically-significant-patient-mortality-risk.

Assessing Aging Physicians

In July 2017, *JAMA Surgery* reviewed an article entitled, "The Aging Physician and the Medical Profession." Authors E. Patchen Dellinger, MD, Carlos A. Pellegrini, MD and Thomas Gallagher, MD reached this conclusion:

> 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. While it is unlikely that this will become a national standard soon, individual health care organizations could develop policies similar to those present at a few US institutions. In addition, large professional organizations should identify a range of acceptable policies to address the aging physician while leaving institutions flexibility to customize the approach. Absent robust professional initiatives in this area, regulators and legislators may impose more draconian measures.

For more, see: http://jamanetwork.com/journals/jamasurgery/article-abstract/2644000 and http://www.reuters.com/article/us-healthcare-physician-retirement/should-older-doctors-be-examined-tested-or-forced-to-retire-idUSKBN1AR22K.

Ensuring Objective Assessment of Current Competence

Christine Niero, PhD wrote in the May 19 *Professional Testing Blog* that the subject of recertification was discussed at a recent meeting of the International Laboratory Accreditation Cooperation (IAF-ILAC). The discussion revolved around the IOS/IEC standard 17024 conformity assessment requirements related to *General requirements for bodies operating certification of persons*. Niero wrote:

> ISO/IEC 17024 requirement 9.6.5 stipulates that certification bodies consider several options for confirming continuing competence, including: a) on-site assessments; b) professional development; c) structured interviews; d) confirmation of continuing satisfactory work and work experience records; e) examination; and f) checks on physical capability in relation to the competence concerned. The responsibility of certification bodies electing any or a combination of these options is to provide evidence of impartiality in assessing continuing competence.