Outcomes and Lessons Learned in a Physician Health Center

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Disclosures:

Dr. Swift is an employee of the Mayo Clinic.

No other disclosures.

A Case – OB or not OB?

- 51 yo OB/GYN
- Referred by employer for Fitness for Duty (FFD) evaluation
- Presented permanent work restriction from PCP stating “may practice GYN but not OB”
- Disclosed “neuropathy” affecting arms

- Employer questions if able to safely perform GYN surgery

Why a Physician Health Center?

- Physicians have unique barriers to care
  - Time constraints
  - Professional relationship with local physicians
  - Confidentiality, especially in own healthcare system
  - May be the only area specialist in topic of concern
- Often resort to self-diagnosis & treatment
  - Or informal “curbside” opinions without thorough evaluation
- Aging physician workforce

Demand for mandatory evaluations

- Employers, licensing boards and physician monitoring programs
- Growth of age-based cognitive screening policies
- Limited options for non-psychiatric diseases/injuries
- Occupational safety evaluations must be
  - Timely
  - Thorough
  - Objective
  - Confidential

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When was the last time you put your health care first?

Mayo Clinic

Physician Health Center

Optimizing the health, safety, and productivity of practicing physicians

- Comprehensive, expert medical evaluations to establish **correct diagnosis and optimal management**
- Objective assessment of how health condition impacts work function
- Unbiased recommendations for practice

Program Description

- Referral source
  - Self
  - Employers
  - Licensing boards
  - Physician monitoring boards
- Scope
  - Comprehensive or targeted medical evaluation
  - Wide variety of specialty consultations and diagnostics
  - Occupational medicine consultation for work-related issues
  - Occupational psychiatry (individual “burnout prevention coaching”)
  - Immersive Healthy Living for Physicians CME course
  - Customized observations (advanced Simulation Center)
  - Formal assessment of fitness for duty

Not an IME!

	Traditional IME	MC Physician Health Center
External Record review	Extensive	Clinically relevant
Physical exam	Focused	Comprehensive
Causation opinion	YES	NO
Diagnostic testing	NO	YES
Specialty consultations	NO	YES
Recommendations to optimize treatment & improve functional status	NO	YES
Prescribe & adjust work restrictions	NO	YES
Recommend accommodations	NO	YES
Facilitate ongoing care	NO	YES

Not a Medicolegal Exam

- Do not accept cases in litigation or preparing to litigate
- Provide medical evaluation and care, not “Exhibit A”

Not Medical Knowledge/Skill Assessment

- NOT “Do they have clinical competence?”
- INSTEAD “Does their impairment affect performance?”
  - Weakness
  - Tremor
  - Sensory loss
  - Vision impairment
  - Tolerance

Consultative mental health care

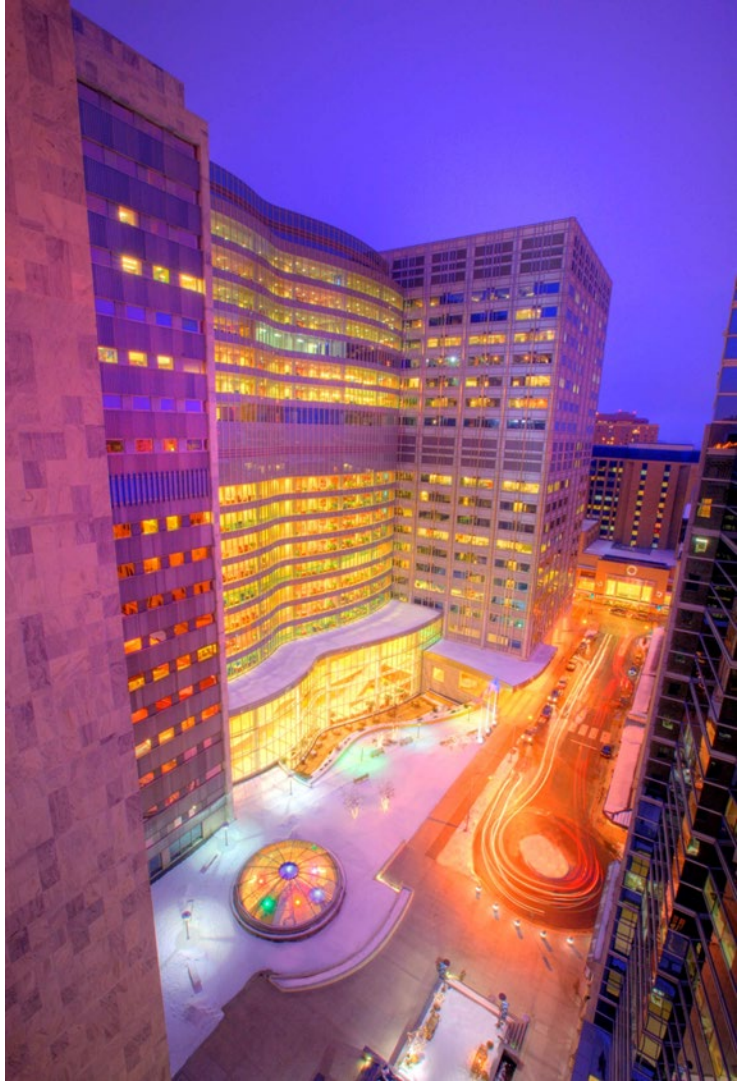
Outpatient psychiatric consults:

- Depression/anxiety
- Bipolar
- Schizophrenia, schizoaffective
- Personality disorders
- Substance use disorders/chemical dependency

- Limited inpatient facilities

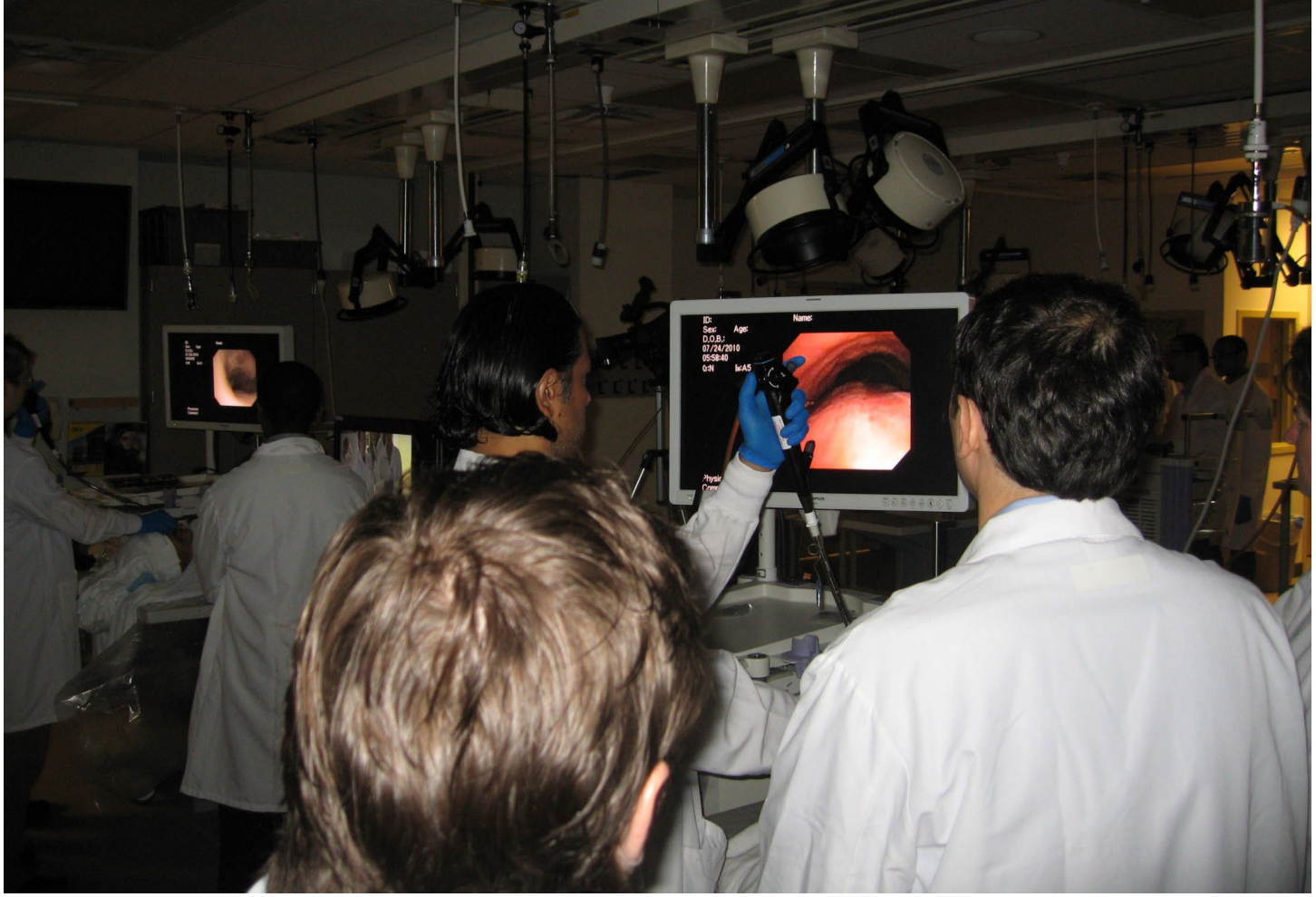
Resources

- 7 Board-certified Occupational Medicine specialists
- Program manager with experience in specialized occupational groups
- Central coordination of schedule
- Over 4,500 consultants
- State-of-the-art Simulation Center and Procedural Skills Lab



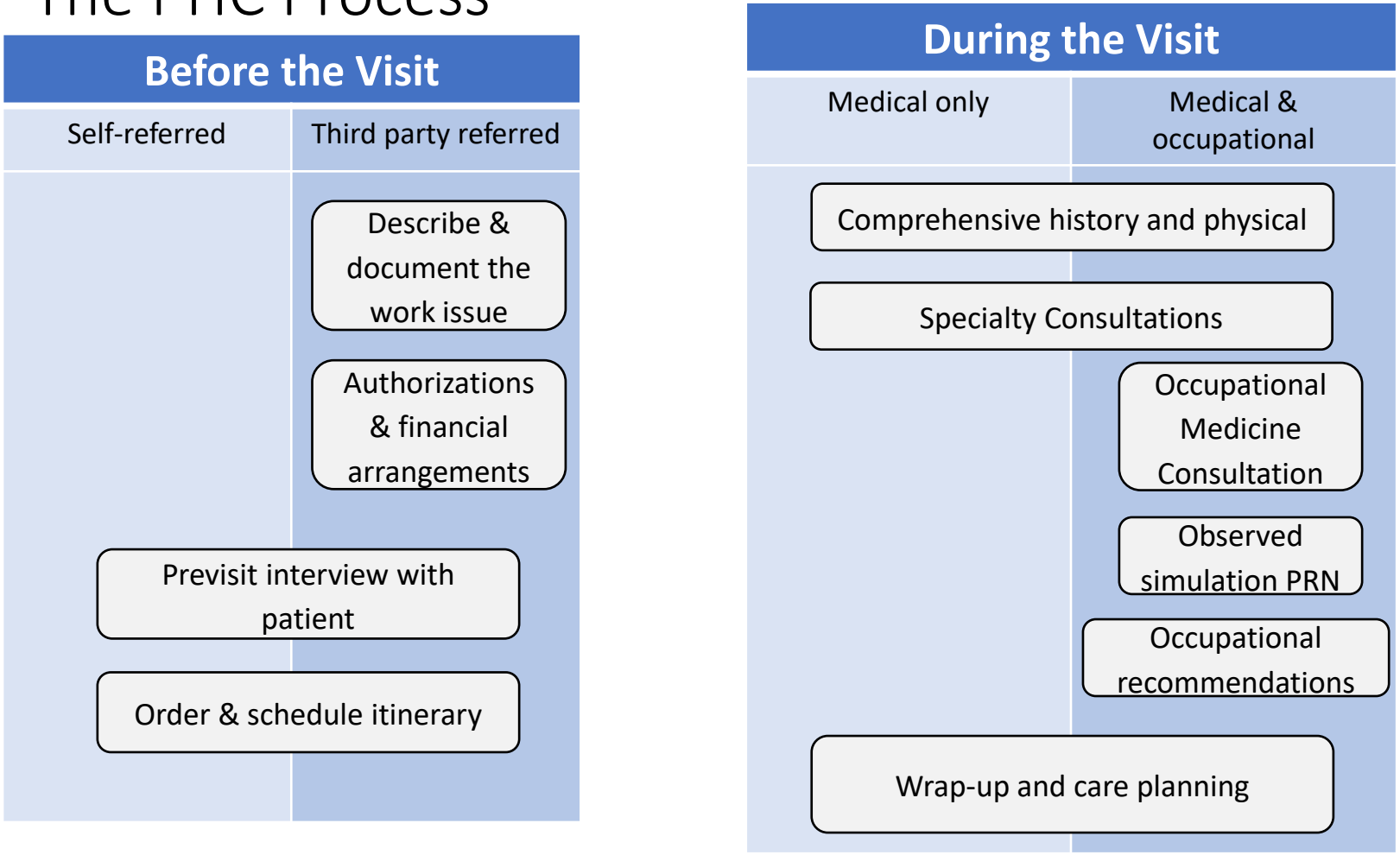
Mayo Clinic Simulation Center

Mayo Clinic Simulation Center



Mayo Clinic Procedural Skills Lab

The PHC Process



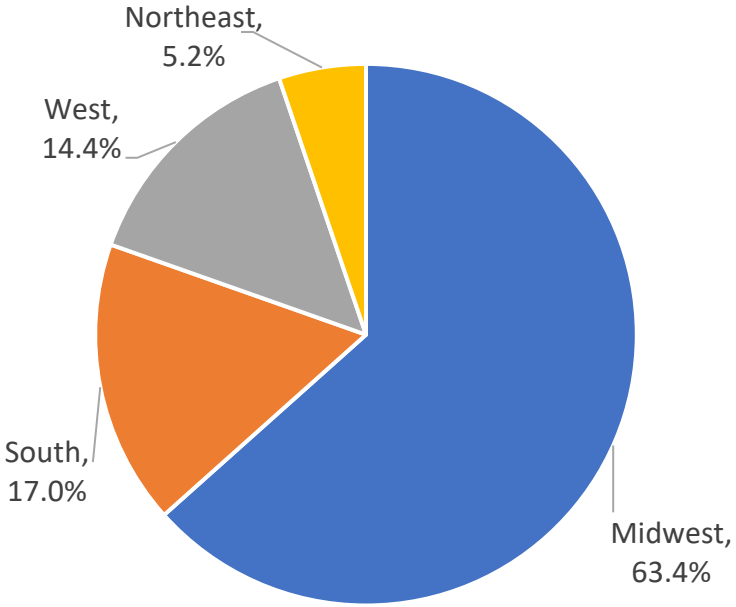
Evaluation of Program Outcomes

- Retrospective chart review
- All consecutive new evaluations (Ineligible if retired or MC employee)
  - Excluded if research authorization denied
  - Excluded if prior evaluation in PHC
- Reason for evaluation
  - Medical care only
  - Occupational evaluation (voluntary or mandatory/Fitness for Duty)
- Demographics (state/region, specialty, age, sex)
- Medical conditions
- Occupational outcomes

Cohort Demographics

	Overall N = 153
Age (y) (mean, range)	56 (29 – 82)
Female	47 (27.0%)
Credentials	
Allopathic or osteopathic physician (MD, MBBS, DO)	143 (93.4%)
Dentist (DDS, DMD)	5 (3.3%)
Nurse Practitioner (DNP)	2 (1.3%)
Chiropractor (DC)	1 (0.7%)
Podiatrist (DPM)	1 (0.7%)
Psychologist (PhD)	1 (0.7%)

Diversity of location, specialty



- From 34 states
- Specialties represented
  - Family Medicine, 14.9%
  - Internal Medicine, 8.5%
  - Cardiology, 7.2%
  - Radiology, 5.2%
  - Ophthalmology, 4.6%
  - Emergency Medicine, Neurology, Orthopedics, Plastic Surgery, all 3.9%
  - Plus 25 more

Nature of Medical Condition

Primary health condition	Overall	Occupational	Non-occupational
Multiple systems	50 (32.7%)	13 (14.9%)	37 (56.1%)
Neurologic - cognitive	28 (18.3)	28 (32.2%)	0
Psychiatric/Mental Health (other than Substance Abuse)	18 (11.8%)	17 (19.5%)	1 (1.5%)
No condition found	13 (8.5%)	8 (9.2%)	5 (7.8%)
Neurologic - noncognitive	12 (7.8%)	8 (9.2%)	4 (6.1%)
Musculoskeletal	10 (6.5%)	5 (5.7%)	5 (7.8%)
Cardiovascular	6 (3.9%)	1 (1.1%)	5 (7.8%)
Substance Abuse	3 (2.0%)	3 (3.4%)	0
Pulmonary	3 (2.0%)	1 (1.1%)	2 (3.0%)
Dermatologic	2 (1.3%)	1 (1.1%)	1 (1.5%)
Endocrine	2 (1.3%)	0	2 (3.0%)
Gynecologic	2 (1.3%)	0	2 (3.0%)
Rheumatologic	2 (1.3%)	2 (2.3%)	0
Gastrointestinal	1 (0.7%)	0	1 (1.5%)
Otolaryngologic	1 (0.7%)	0	1 (1.5%)

Occupational Outcomes

- 2/3 voluntary; 1/3 mandatory
- 60% able to practice without restrictions, or only temporary restrictions
- 24% unable to practice
  - Over half of these due to cognitive impairment
- 16% able to practice with a permanent restriction (e.g. no overnight call, work hour limit, specific physical restriction)

Multivariable analysis of work outcomes (Ordinal logistic regression)

- Work recommendation NOT independently associated with:
  - Age
  - Sex
  - Mandatory vs voluntary evaluation
  - Work status at time of referral
  - Region
- Neurologic condition associated with permanent restriction or inability to practice (OR 14.2, 95% CI 5.8, 36.4)
- Psychiatric condition associated with temporary restriction (OR 6.2, 95% CI 2.3, 17.5)

Limitations and Caveats

- Tertiary care center, skewed toward more complex medical conditions or occupational quandaries
- Observational study; subject to confounding
- High rate of research authorization opt-out for mandatory referrals

Case, continued – OB or not OB?

- B/L cervical osteoarthritis with nerve impingement
- Symptoms resolved with corticosteroid and rest
- Remains asymptomatic unless prolonged extension or side flexion or overhead lift/push/pull
  - Prolonged forward flexion (robotic or open laparoscopic surgery) does not exacerbate
- Customized observation in Simulation Center

- Room set-up matched photos from employer
- Simulations
  - Fetal monitoring
  - Perineal massage
  - Routine delivery
  - Precipitous delivery
  - Shoulder dystocia
  - Episiotomy repair
  - Bedside ultrasound
- Objective measurements i.e. goniometer

Findings

- Fetal monitor – requires craning neck
- Perineal massage – OK (standing)
- Routine & Precipitous delivery – OK
- Shoulder dystocia – awkward neck postures
- Episiotomy repair – prolonged neck extension + side flexion
- Bedside ultrasound – prolonged static neck rotation (over 90 degrees!) + extension

OB/GYN Case Recommendations

- Detailed report with observations and measurements.

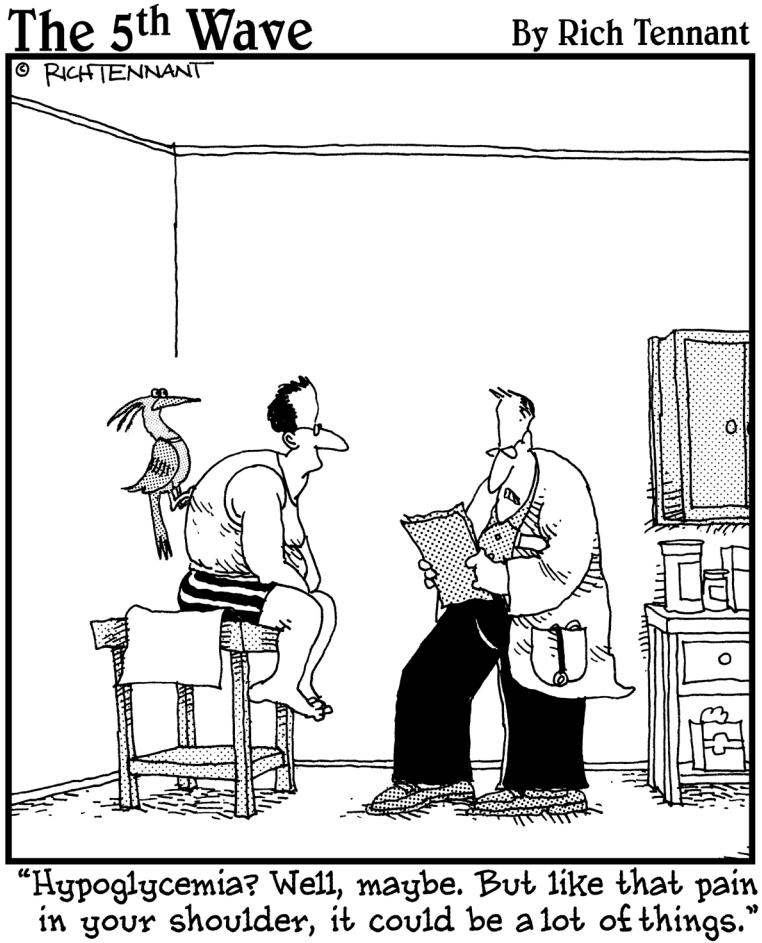
- Restrictions issued:
  - Limit neck extension over 20 degrees or rotation or side flexion over 45 degrees to 15 minutes at a time, and cumulatively an hour per day.
  - Occasional lifting, pushing, or pulling up to 20 lb of force above shoulder height.

- No medical restriction on forward neck flexion, use of arms/hands, or below-shoulder weight handling.

Lessons Learned

- A wide variety of diagnoses can impact ability to perform optimally.
- The majority of self-referred physicians required multispecialty care.
- For occupational concerns:
  - Most physicians with health issues could safety return to practice.
  - Significant cognitive impairment carries highest risk of inability to practice.
  - Psychiatric illness usually requires only temporary restrictions.
- Helpful resources in complex cases:
  - Advanced simulation center
  - Experienced occupational medicine physician

A Framework for Evaluating Physician Fitness for Duty



Step 1: Diagnosis

Diagnoses found in “suspected dementia”

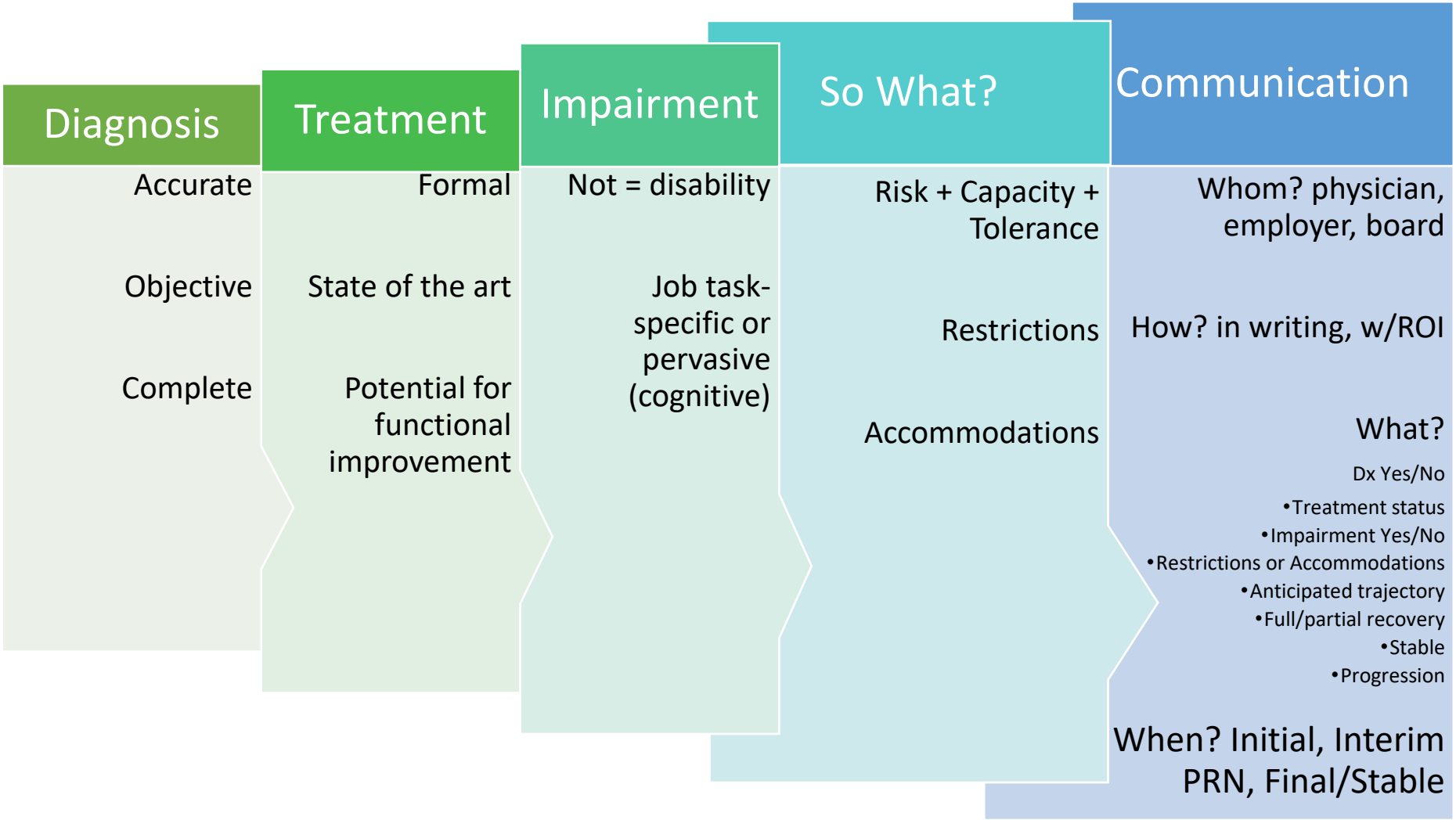
- Hearing loss
- Depression
- Bipolar disorder
- Sleep disorder
- Substance use disorder
- Personality disorder
- Cultural differences
- Miscommunication
- Medication adverse effect
- Multiple sclerosis
- Parkinson’s disease
- Alzheimer’s dementia
- Lewy body dementia
- Mild cognitive impairment
- Adult learner with basic computer skills meets EMR


DAMMIT, JIM, I'M A DOCTOR,
NOT A COMPUTER EXPERT

Step 2: Treatment

- "A physician who treats himself has a fool for a patient" (attributed to Sir William Osler, b.1849 – d. 1919)
- If the man who is his own lawyer has a fool for his client, it is equally true that, under serious circumstances, **the man who is his own doctor has a simpleton for his patient.** (London "Notes and Queries, **1874)**
- …in such (gout) cases **no man ought to be his own physician, for fear of having a fool for his patient.** (William Grant, **1781)**
- **He that Consults his Physician, and will not Follow his Advice, must be his Own Doctor:** But let him take the Old Adage along with him. **He that Teaches Himself has a Fool to his Master.** (Sir Roger L'Estrange 1692)

- Over 60% of physicians resort to self-treatment


Diagnosis
Accurate
Objective
Complete
Treatment
Formal
State of the art
Potential for functional improvement
Impairment
Not = disability
Job task-specific or pervasive (cognitive)
So What?
Risk + Capacity + Tolerance
Restrictions
Accommodations
Communication
Whom? physician, employer, board
How? in writing, w/ROI
What?
Dx Yes/No
•Treatment status
•Impairment Yes/No
•Restrictions or Accommodations
•Anticipated trajectory
•Full/partial recovery
•Stable
•Progression
When? Initial, Interim PRN, Final/Stable

Questions?

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