

Treating All Risks: The Cognitive and Physical Assessment of Late-Career Practitioners

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ABSTRACT: This article focuses on a significant and timely issue: factual and legal support for the proposition that adopting late-career practitioner policies fosters safe patient care and is not per se unlawfully discriminatory. Written from the perspective of a management-side employment attorney, this article seeks to explain the following: first, the potential patient harm from late-career practitioners whose skills have eroded and second, the potential employment discrimination claims from late-career practitioners if the medical staff institutes a late-career practitioner screening policy. While statutes prohibiting employment discrimination generally protect only “employees,” some courts have found “employee” status in arrangements that were established as independent contractor relationships. Courts also have applied public accommodation statutes with analogous protections. Therefore, hospitals should be cognizant of the possibility that even nominally independent practitioners may be able to pursue discrimination claims arising out of the application of late-career practitioner policies to them.

Michael R. Bertoncini & Katherine Lam, *Treating All Risks: The Cognitive and Physical Assessment of Late-Career Practitioners*, J. HEALTH AND LIFE SCI. L., Nov. 2021, at 50. © American Health Law Association, www.americanhealthlaw.org/journal. All rights reserved.

Late-Career Practitioners

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INTRODUCTION

Today's medical staff leaders find themselves at the crossroads of two competing sets of risks: potential patient harm from late-career practitioners whose skills have eroded, and potential employment discrimination claims from those same practitioners if the medical staff institutes a late-career practitioner policy to assess mental and physical health of all practitioners over a certain age.¹ While the risk from potential negligent credentialing claims is well known, the absence of binding case law regarding employment discrimination claims arising from late-career practitioner policies makes this risk more difficult to assess. This uncertainty poses challenges for medical staff leaders facing a substantial increase in the number of physicians practicing past 65 years of age, a looming physician shortage, and the prevalence of the employed physician model. This article discusses factual and legal support for the proposition that adopting late-career practitioner policies fosters safe patient care and is not per se unlawfully discriminatory.

THE RESPONSIBILITY OF ORGANIZED MEDICAL STAFFS: PROVIDING COMPETENT CARE

The core responsibilities of organized hospital medical staffs are the promotion of patient safety and quality of care.² Competent health care practitioners enable the medical staff to accomplish this goal. Competence is the ability to practice with reasonable skill and safety.³ Impaired health care practitioners decrease the medical staff's ability to provide a high level of care.⁴ The concept of impairment is broader than problems caused by drug or alcohol use. Impairment occurs whenever a health care practitioner's health or wellness is compromised.⁵ "When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired."⁶

1 The risk from discrimination claims is not limited to employed physicians. See *Salamon v. Our Lady of Victory Hosp.*, 867 F. Supp. 2d 344 (W.D. N.Y. 2012) (denying hospital's motion for summary judgment because dispute existed as to whether hospital exercised sufficient control over medical staff member to render her an "employee" within the meaning of Title VII of the Civil Rights Act of 1964, using similar definition of "employee" to that in the Americans with Disabilities Act (ADA)); *Robinson v. CareAlliance Health Servs.*, No. 2:13-cv-01916-RMG (allowing a non-employee physician with staff privileges at the defendant hospital to proceed with claims under Title III of the ADA); *Menkowitz v. Pottstown Mem'l Med. Ctr.*, 154 F.3d 113 (3d Cir. 1998) (applying the public accommodations protections of Title III of the ADA to a non-employee physician), *criticized by* EEOC v. J. H. Routh Packing Co., 246 F.3d 850 (6th Cir. 2001), *distinguished by* *Wojewski v. Rapid City Reg'l Hosp., Inc.*, 450 F.3d 338 (8th Cir. 2006). Some district courts also have questioned, criticized, or distinguished the Menkowitz decision.

2 *Organized Medical Staff: Code of Medical Ethics Opinion 9.5.1*, AMA, <https://www.ama-assn.org/delivering-care/ethics/organized-medical-staff>.

3 Krista L. Kaups, *Competence not Age Determines Ability to Practice: Ethical Considerations about Sensorimotor Agility, Dexterity, and Cognitive Capacity*, 18 AMA J. ETHICS 1017, 1017 (2016) (discussing aging-associated changes in sensorimotor and cognitive skills).

4 WILLIAM A. MCDADE, REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (A-15): COMPETENCY AND THE AGING PHYSICIAN 8 (2015), <https://www.cppph.org/wp-content/uploads/2016/02/AMA-Council-on-Medical-Education-Aging-Physician-Report-2015.pdf>.

5 *Id.*

6 *Id.*

Many medical staffs are adopting late-career practitioner policies to address concerns about age-related impairment. These policies generally require all members of the medical staff who are over a certain age (usually 65-70) to undergo physical and cognitive screening as part of their application for renewal of clinical privileges. Counsel have long advised medical staffs of the potential legal risks associated with such policies, but the dearth of case law involving these policies has made it challenging to set specific parameters to mitigate this risk. Recent litigation by the U.S. Equal Employment Opportunity Commission (EEOC) challenging an academic medical center's late-career practitioner policy highlights these risks.⁷

THE DRAMATIC INCREASE IN OLDER PHYSICIANS AND AGE-RELATED CHANGES

In 1975, the total number of physicians who were 65 or older in the U.S. was 50,993.⁸ In 2017, that number grew nearly six times to 300,752 physicians who were 65 or older in the U.S.⁹ In 2017, 29% of the one million licensed physicians were 60 or older.¹⁰ As an example, at least one physician is older than 65 in the majority of physician anesthesiologist groups.¹¹

Additionally, the number of actively practicing physicians 60 and older increased by 30% between 2010 and 2016,¹² while the number of actively practicing physicians 49 and younger only increased by 10% during that same period.¹³ Further, this trend also is affected by the fact that the mean retirement age in the U.S. has increased.¹⁴ The mean retirement age in 2005 was 63.3 but in 2014, that increased to 67.7.¹⁵ The trend also is exacerbated by the fact that physicians tend to practice past the average retirement age.¹⁶

These trends regarding the age of the physician population are occurring at a time when the U.S. is simultaneously facing a significant physician shortage.¹⁷ The U.S. is expected to have a physician deficit of 61,700-94,700 by 2025.¹⁸ This shortage will coincide with a “rising proportion of elderly people . . . who are anticipated to have increasingly complex health care needs.”¹⁹ The combination of an aging physician population and a shortage of physicians presents unique challenges for hospital medical staffs as they aim to promote patient safety

7 U.S. Equal Opportunity Comm'n v. Yale New Haven Hosp., Inc., No. 3:20-cv-00187 (D. Conn. June 29, 2021).

8 Carol Berkowitz, REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION: COMPETENCY OF SENIOR PHYSICIANS 1 (2018).

9 *Id.*

10 Ilene N. Moore, *Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory?*, 28 HEALTH MATRIX 95 (2017), <https://core.ac.uk/download/pdf/214112427.pdf>.

11 Comm. on Occupational Health, *Statement on the Aging Anesthesiologist*, AMERICAN SOCIETY OF ANESTHESIOLOGISTS (Oct. 17, 2018), <https://www.asahq.org/standards-and-guidelines/statement-on-the-aging-anesthesiologist>.

12 *Id.*

13 *Id.*

14 *Id.*

15 *Id.*

16 *Id.*

17 *Id.*

18 *Id.*

19 Kaups, *supra* note 3, at 1019.

and quality of care. These unique challenges can at least partially be alleviated through cognitive and physical screening of late-career practitioners.

While late-career practitioners may have the same level of commitment to providing a high level of care, “age-related changes can influence their ability to do so.”²⁰ For example, a review of 62 physician-competence studies found that physician performance, which was gauged by adherence to clinical guidelines, decreased with years in practice.²¹ As years in practice increased, physician performance decreased.²² In 2006, “approximately 8,000 physicians in the US were suffering from dementia....”²³ “[O]verall, physicians scored higher in cognitive functioning from 25-55, but [t]here was a consistent and more precipitous decline with increasing age in the areas of cognitive function . . . inductive reasoning, verbal memory, and overall reasoning....”²⁴

Another study found late-career physicians may suffer from “deficiencies in the neuropsychological functions required to practice competently.”²⁵ These functions include “verbal problem-solving, visual-spatial problem-solving, learning and memory, verbal fluency, attention, and mental tracking.”²⁶ Many of these functions are critical to providing a high level of care and therefore, it is essential that medical staffs address this problem.²⁷

Finally, increased years of practice was associated with increased mortality ratios for “coronary bypass procedures.”²⁸ The trend held true even after “accounting for volume.”²⁹ Mortality ratios are defined as “the ratio of the observed to the predicted patient mortality rate as determined by detailed clinical information.”³⁰ In addition to the fact that the skills of older physicians may decline over time, these increased mortality ratios also were partially attributed to the fact that, unlike late-career surgeons, the younger surgeons received “training in the newer and most effective surgical techniques.”³¹

20 *Id.* at 1017.

21 *Id.*

22 *Id.*

23 *Id.*

24 Jonathan H. Burroughs et al., *The Aging Physician: Balancing Safety, Respect, and Compliance*, MEDSTAFF NEWS, 2013, at 10, http://www.hallrender.com/health_care_law/library/articles/1465/MedStaff_News_AHLA_March_2013.pdf (citing DOUGLAS H. POWELL, PROFILES IN COGNITIVE AGING (HARVARD UNIV. PRESS, 1994)).

25 Moore, *supra* note 10, at 101 (discussing the scope of the issue of screening older physicians).

26 *Id.*

27 *Id.*

28 Arthur J. Hartz et al., *Prestige of Training Programs and Experience of Bypass Surgeons As Factors in Adjusted Patient Mortality Rates*, 37 MED. CARE 93, 101 (Jan. 1999).

29 *Id.*

30 *Id.*

31 *Id.*

Surgeons face particular challenges as technology and surgical procedures change over time.³² Some late-career surgeons fail to keep up to date as practices evolve,³³ and are “less likely to prescribe appropriate medications or incorporate new treatment strategies into their practices.”³⁴

While the studies cited above support implementing late-career practitioner policies, medical staff leaders also should be aware that at least one study of physician performance based on claims data did not find a correlation between quality of care and years of practice.³⁵

THE HEALTH CARE INSTITUTION'S COMPROMISED POSITION

The growing body of studies showing the effects of aging on cognitive function and dexterity leaves medical staff leaders to debate how best to address these risks to patient safety because “currently, there is no national standard for screening physicians who have reached a certain age.”³⁶ Moreover, as discussed later in this article, requiring practitioners of a certain age to undergo physical or mental screening or instituting a mandatory retirement age for health care practitioners may run afoul of state and federal anti-discrimination laws.³⁷

THE RISK OF FAILING TO PROPERLY ASSESS: LOWER QUALITY PATIENT CARE

The College of Physicians and Surgeons of Ontario (CPSO), Ontario, Canada’s medical licensing authority, sponsors a program that assesses physician competency.³⁸ Of the physicians assessed, some are identified as moderate to severely incompetent.³⁹ John Turnbull M.D. Ph.D. conducted a study to determine whether physicians who were presumed incompetent actually suffered from neuropsychological impairments that hindered their competence and caused a failure to improve, even with continuing medical education.⁴⁰ Fourteen of the 45 physicians studied were deemed satisfactory.⁴¹ Of the 14, 12 had no cognitive impairment, minimal cognitive impairment, or mild cognitive impairment.⁴² Thirty-one of the 45 physi-

32 Joy Daughtery Dickinson, *As surgeons age, are they putting your program at risk?*, RELIAS MEDIA (Apr. 1, 2013), <https://www.reliasmmedia.com/articles/63084-as-surgeons-age-are-they-putting-your-program-at-risk>.

33 *Id.*

34 MCDADE, *supra* note 4, at 3.

35 *Id.*

36 *Id.* at 5.

37 ASSESSING LATE CAREER PRACTITIONERS: POLICIES AND PROCEDURES FOR AGE-BASED SCREENING: A GUIDELINE FROM CALIFORNIA PUBLIC PROTECTION AND PHYSICIAN HEALTH, INC. 14 (2015), <https://www.cppph.org/wp-content/uploads/2015/07/assessing-late-career-practitioners-adopted-by-cppph-changes-6-10-151.pdf> [hereinafter CPPPH].

38 John Turnbull et al., *Competence and Cognitive Difficulty in Physicians: A Follow-Up Study*, 81 ACAD. MED. 915 (2006).

39 *Id.*

40 *Id.*

41 *Id.* at 916.

42 *Id.*

cians studied were deemed unsatisfactory.⁴³ Of the 31, 12 had moderate or severe cognitive impairment.⁴⁴ Ultimately, Dr. Turnbull determined that neuropsychological testing is useful when assessing physician competence⁴⁵ because neuropsychological testing was indicative of physician performance.⁴⁶ As a note, although Dr. Turnbull stated that “age was not identified as a major impediment to remediation,” he still identified the fact that neuropsychological performance decreases with age.⁴⁷

THE FAILURE OF EXISTING METHODS TO PROPERLY ASSESS COMPETENCY

This section will discuss current methods that often prove unreliable in terms of adequately screening for competency, including self-assessment, colleague assessment, and existing programs.

Self-assessment

There are a limited number of reliable tools that can determine health care practitioner competence, and many of the existing methods fail to properly assess competency.⁴⁸ Physician self-assessment is an unreliable tool, regardless of the degree of impairment, because practitioners may not be able to “accurately assess their own functioning.”⁴⁹ Although a health care practitioner’s professional duty includes self-assessment of their cognitive and physical health, it is imperative that medical staffs conduct these screenings rather than health care practitioners themselves⁵⁰ because even those with only mild cognitive impairment often display a lack of insight regarding their impairments.⁵¹

Colleague Reporting

Most physicians believe that the appropriate authorities should be made aware of physicians who are impaired or incompetent; however, colleague-reporting is not a reliable method.⁵² Forty-five percent of individuals who had direct personal knowledge of an impaired physician in their own hospital group or practice did not consistently report that impaired physician.⁵³ One example of this underreporting involved an 82-year-old surgeon who struggled so much

43 *Id.*

44 *Id.*

45 *Id.*

46 *Id.*

47 *Id.* at 917, 918.

48 *Id.* at 915.

49 Kaups, *supra* note 3, at 1018 (discussing aging-associated changes in sensorimotor and cognitive skills).

50 *Id.*

51 Kaups, *supra* note 3, at 1017.

52 McDADE, *supra* note 4, at 8.

53 *Id.*

with his practice that his colleagues took time away from their own patients and often offered to provide the surgeon with assistance, but nevertheless failed to report the surgeon.⁵⁴

Existing Programs

Further, screening late-career practitioners is necessary because many of the existing Continuing Medical Education (CME) programs fail to meaningfully help health care practitioners “maintain their quality of care.”⁵⁵ For example, the American Board of Medical Specialties (ABMS) sponsors Maintenance of Certification (MOC) programs. Their 24 Member Boards require most health care practitioners to seek recertification periodically (generally every 10 years).⁵⁶ Recertification entails completing assessments that test “medical knowledge, clinical competence and skills in communicating with patients” successfully.⁵⁷ However, the impact of the MOC programs is very limited because many late-career physicians either have board certifications that are not time limited or they were never board certified because their medical staffs “grandfathered” them and made them exempt from a board certification requirement, which became effective *after* their initial application for privileges was granted.⁵⁸

While state licensing boards have the authority to regulate health care practitioner competence, these boards generally only revoke the licenses of physicians who are an “immediate threat to the public welfare....”⁵⁹ These types of actions are reactive rather than proactive and organized.

For the reasons cited above, proactive universal screening of late-career practitioners is a more effective means of ensuring that older members of the medical staff are competent to practice.

THE BENEFITS OF SCREENING TO ASSESS COMPETENCY

In order to fulfill their responsibility to ensure that health care practitioners are not impaired and thus still able to provide a high level of care to patients, many medical staffs have instituted programs that screen or test late-career practitioners.⁶⁰ While the studies cited in this article provide a basis for such screening, medical staff leaders must be aware of arguments that such screening based solely on a practitioner’s age, without any evidence of a particular practitioner’s impairment, violates state and federal anti-discrimination laws.⁶¹

54 Dickinson, *supra* note 32.

55 McDADE, *supra* note 4, at 10.

56 *Id.*

57 *Id.* at 9.

58 *Id.*

59 *Id.*

60 Moore, *supra* note 10, at 95.

61 *Id.*

Screening Can Identify Impairments Before Late-Career Practitioners or Their Colleagues Detect Them: The universal application of late-career practitioner screening to all practitioners over a certain age regardless of whether they have shown signs of impairment is part of the reason it is so effective.⁶² These screenings typically include an assessment of the practitioner's ability to engage in physical activities associated with their practice, like bending and lifting, and testing of cognitive functioning. Many diseases that occur with increased age and their effects occur insidiously and with few symptoms.⁶³ Even when symptoms are occurring, the affected health care practitioner and those around her may fail to recognize the symptoms.⁶⁴ In addition, universal screenings provide an opportunity to detect problems that may go unreported by a practitioner's colleagues.

Screening allows hospital medical staffs to assess a practitioner's competency when the symptoms may just be developing and have not yet been recognized by the practitioner or colleagues,⁶⁵ and they can pinpoint the exact areas in which a practitioner lacks competence. If identified early, the medical staff can work with the health care practitioner to improve her competence or assist in the transition away from treating patients.

Screening Allows Medical Staffs to Show Their Commitment to Patient Safety: Organized hospital medical staffs that develop late-career practitioner screening policies demonstrate a high level of accountability and communicate to the public that they sincerely value patient safety.⁶⁶ Setting practice requirements and conducting screenings to assess whether a practitioner's skills meet those practice requirements ensures that a hospital medical staff is able to provide high quality care.⁶⁷ These screenings also provide a service to their practitioners by warning them of any health issues that may otherwise go undetected and potentially lead to patient harm.

EARLY ADOPTERS AND PRIMARY SUPPORTERS OF SCREENING LATE-CAREER HEALTH CARE PRACTITIONERS

In a survey conducted at a Coalition for Physician Enhancement conference, most of the individuals surveyed "favored implementation of age-based screening of physicians' competence."⁶⁸ Seventy-two percent of respondents stated screening should begin when a health care practitioner turns 65 or 70.⁶⁹ The individuals surveyed included "staff from physician assessment centers, attorneys and state medical board members..."⁷⁰

62 Dickinson, *supra* note 32.

63 CPPPH, *supra* note 37, at 14.

64 *Id.*

65 *Id.*

66 McDADE, *supra* note 4, at 12.

67 *Id.*

68 *Id.* at 4.

69 *Id.* at 9.

70 *Id.* at 4.

The survey respondents were not the only medical professionals in favor screening late-career practitioners. The American Medical Association (AMA) has studied the issue of assessing them multiple times.⁷¹ Despite the potential legal hurdles, the AMA developed eight guiding principles for the assessment of senior/late-career physicians.⁷²

Overall, the AMA states that assessments must be based in evidence and on medical ethics principles.⁷³ Additionally, guidelines should be relevant to physician practices, accountable to the public, fair and equitable to the physicians being assessed, transparent to all parties (including the public), supportive of practitioners, and cost conscious.⁷⁴ Further, the AMA emphasized that the main goal of assessing late-career practitioners should be to “fulfill the ethical obligation of the profession to the health of the public and patient safety.”⁷⁵

The University of Virginia Health System and the Stanford Hospital and Clinics (Stanford) both developed age-related screening policies.⁷⁶ The former instituted “mandatory physical and cognitive examinations every two years for physicians and some other members of the clinical staff, beginning at age 70.”⁷⁷ Stanford’s policy included “a peer evaluation of clinical performance, a cognitive examination, and a comprehensive history and physical examination every two years for physicians aged 75 and older.”⁷⁸ However, senior faculty members at Stanford voted to reject this policy.⁷⁹

Other organized hospital medical staffs that have developed screening policies to examine “practice patterns and physician abilities” include Driscoll Children’s Hospital in Texas and Stanford Lucille Packard Children’s Hospital.⁸⁰ Internationally, professional organizations such as the Royal Australian College of Surgeons – The College of Surgeons of Australia and New Zealand, and the College of Physicians and Surgeons of Ontario also have created competence assessments that occur throughout surgeon’s careers.⁸¹ The strategies of other countries include allowing late-career health care practitioners to “switch to part-time work.”⁸²

LEGAL AND REGULATORY BACKGROUND

While there is growing support among medical staff leaders and professional organizations for screening late-career practitioners, state and federal anti-discrimination laws complicate the

71 Kaups, *supra* note 3, at 1017; MCDADE, *supra* note 4, at 8.

72 Kaups, *supra* note 3, at 1017; MCDADE, *supra* note 4, at 8.

73 Kaups, *supra* note 3, at 1017; MCDADE, *supra* note 4, at 8.

74 Kaups, *supra* note 3, at 1017; MCDADE, *supra* note 4, at 8.

75 Kaups, *supra* note 3, at 1017.

76 *Id.* at 1020.

77 Kaups, *supra* note 3, at 1017.

78 *Id.*

79 *Id.*

80 MCDADE, *supra* note 4, at 5.

81 Kaups, *supra* note 3, at 1020; MCDADE, *supra* note 4, at 6.

82 Kaups, *supra* note 3, at 1019.

issue⁸³ as both sets of law require that hospital medical staffs “engage in active oversight of the quality of care rendered by physicians practicing at their facilities.”⁸⁴ Further, ample case law shows that organized hospital medical staffs can be directly liable for patient injuries caused by physicians “where there was evidence of deficiencies in the physician’s skills or judgment that posed a danger to patients.”⁸⁵

Anti-age Discrimination Laws Impose Restrictions on Age-based Screening

State and federal laws impose restrictions on a medical staff’s ability to conduct age-based screenings.⁸⁶ Anti-discrimination laws establish “a physician’s right to be free from discrimination based on race, color, gender, sexual orientation, national origin, age and disability.”⁸⁷ The federal Age Discrimination in Employment Act (ADEA) (and state laws) protect employees age 40 and older from discrimination by making it unlawful for an employer: “(1) . . . to discharge . . . or otherwise discriminate against any individual with respect to his . . . terms, conditions, or privileges of employment, because of such individual’s age; (2) to limit, segregate, or classify his employees in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s age....”⁸⁸ The ADEA contains some industry-based exceptions to this general prohibition; for example, out of a public safety interest, airlines may make employment contingent upon certain age criterion.⁸⁹ However, there is no mandatory retirement age for physicians and as of now, the ADEA would prohibit such a policy.⁹⁰

There is an exception in the ADEA permitting employers to consider age in making employment decisions “where age is a bona fide occupational qualification [BFOQ] reasonably necessary to the normal operation of the particular business....”⁹¹ However, courts construe this exception narrowly. The approach taken by the courts is consistent with the EEOC’s regulations on the ADEA: “[i]f the employer’s objective in asserting a BFOQ is the goal of public safety, the employer must prove that the challenged practice does indeed effectuate that goal and that there is no acceptable alternative which would better advance it or equally advance it with less discriminatory impact.”⁹² Pointing to the studies about the physical and mental effects of aging cited in this article, employers can argue that age-based screening meets the goal of maintaining public safety. Critics of late-career practitioner

83 CPPPH, *supra* note 37, at 3.

84 *Id.*

85 *Id.*

86 *Id.*

87 *Id.*

88 29 U.S.C. § 623(a)(1); (a)(2) (2021).

89 *Pro. Pilots Fed’n v. FAA*, 118 F.3d 758 (D.C. Cir. 1997), *cert. denied*, 523 U.S. 1117 (1998), *distinguished by Berry v. Astrue*, No. C08-5149FDB-KLS (W.D. Wash. Jan. 26, 2009).

90 29 U.S.C. § 623(a)(1); (a)(2).

91 *Id.* § 623(f)(1).

92 29 C.F.R. § 1625.6(b) (2021).

policies often argue that more rigorous monitoring of the performance of all physicians regardless of age is an effective alternative to age-based screening. However, this argument fails to recognize the reality of how practitioners perform their duties and does not take into account the underreporting of physician impairment noted in studies of the health care field. Nor does this argument factor in the patient harm that can better be prevented through age-based screening than a case-by-case approach to physician monitoring.

Anti-disability Discrimination Laws Impose Restrictions on Employer Rights to Conduct Medical Exams

Employers also are bound by the federal Americans with Disabilities Act (ADA) and similar state laws, which makes it unlawful for employers to discriminate against employees based on a disability. “No covered entity [which covers healthcare employers with 15 or more employees] shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.”⁹³

The ADA has a three-part definition of disability: a “physical or mental impairment that substantially limits one or more of the major life activities,” “a record of such impairment” or that the individual is regarded by their employer “as having such impairment...”⁹⁴ The ADA requires all employers, including organized hospital medical staffs, to assess an individual’s abilities based on their “ability to perform essential functions of [the] position in question” and the potential reasonable accommodations that might enable the individual to overcome job-related barriers.⁹⁵ The ADA only permits employers to require an employee to undergo a medical exam when that medical examination is job related and consistent with business necessity.⁹⁶

In order to avoid claims for ADA violations, hospital medical staffs need to provide reasonable accommodations that enable a qualified practitioner with a disability to practice safely.⁹⁷ This requires an employer to conduct an interactive process with the individual health care practitioner to assess that practitioner’s needs.⁹⁸ The EEOC recommends that employers do the following as part of that interactive process:

1. analyze the particular job involved and determine its purpose and essential functions;
2. consult with the employee to ascertain the precise job-related limitations imposed by the disability and how they could be overcome;

93 42 U.S.C. § 12112(a).

94 29 C.F.R. § 1630.2(g) (1).

95 *Deane v. Pocono Med. Ctr.*, 142 F.3d 138, 140 (3d Cir. 1998); *Ammons v. Aramark Unif. Servs.*, 368 F.3d 809, 819 (7th Cir. 2004).

96 29 C.F.R. § 1630.14(c).

97 CPHPH, *supra* note 37, at 13.

98 *Id.*

3. in consultation with the employee, identify potential accommodations and assess the effectiveness of each in enabling the employee to perform his functions; and
4. consider the preference of the employee and implement the accommodation that is most appropriate for both the employee and employer.⁹⁹

While an employer does not have to choose the individual's first choice for an accommodation, the choice simply has to be effective.¹⁰⁰ The cognitive and physical screening components of a late-career practitioner policy can be used to assist employers in fulfilling their interactive process obligations. If the employer's concerns about an employee's performance would not be remedied through a reasonable accommodation, and if they are so strong that they pose a significant threat to the safety of patients, such a direct threat could justify a restriction or denial of medical staff privileges without violating the ADA.¹⁰¹

Thus, hospital medical staffs need to balance the tension between promoting quality of care and accommodating the rights of individual practitioners.¹⁰² To avoid liability under the ADA, medical staffs will need to establish that the late-career practitioner policies are job-related and consistent with business necessity. To meet this burden, they should adopt screenings that are tied to the job duties of medical staff members. One may argue that these screenings should be different based on the practitioner's specialty. For example, the physical screening for a psychiatrist may be different than that used for a surgeon. The business necessity requirement at least arguably is met by the general need to provide safe patient care and the threat posed by the effects of aging described in the studies cited in this article.

It is important to note that in a case filed by the EEOC against an academic medical center in 2020, the EEOC argued the employer's late-career practitioner policy violated both the ADEA and the ADA by subjecting employees to an unlawful medical exam.¹⁰³ The late-career practitioner policy at issue in that case requires neuropsychological and ophthalmologic exams for medical staff applicants who are 70 or older. The EEOC has argued the employer may only avoid liability under the ADEA if it can establish the policy is "reasonably necessary to the essence of his business" and that the employer "is compelled to rely on age as a proxy for th[ose] safety-related job qualifications."¹⁰⁴ The EEOC also has argued the employer must demonstrate the medical exams required by the policy are "job-related and consistent with business necessity" to avoid liability under the ADA.¹⁰⁵

99 29 C.F.R. § 1630.9.

100 *Id.* § 1630.9(d).

101 *Id.*

102 CPPPH, *supra* note 37, at 3.

103 U.S. Equal Opportunity Comm'n v. Yale New Haven Hosp., Inc., No. 3:20-cv-00187 (VLB) (D. Conn. June 29, 2021).

104 *Id.*

105 *Id.*

CREATING THE RIGHT INFRASTRUCTURE: PROPOSED SOLUTIONS

It is important that hospital medical staffs have policies and practices in place that address potential risks associated with late-career practitioners. These policies need to mitigate the legal, ethical, and moral risks that can accompany such policies, as well as potential adverse reactions from practitioners, such as large numbers of competent practitioners who decide to retire earlier than planned as a result of such policies, and practitioners who may refuse to comply and seek to exercise fair hearing rights to challenge any associated refusal to grant privileges. When developing and implementing such policies, it is therefore critical to (1) orient all physicians to the organization's strategic vision, culture, values, and mutual expectations; (2) create a roadmap for a policy/structure that will enable practitioners to be successful; and (3) develop a communications plan for rolling out the late-career practitioner policy.

Strong medical staff support is essential to the successful implementation of a late-career practitioner policy. To garner this support, hospital leaders must engage the medical staff well in advance of establishing the policy. The starting point should be studies like those cited in this article showing the effects of aging on manual dexterity and cognitive function. This messaging should be coupled with a clear statement that there is no intent to push out all practitioners of a certain age. The focus must be on patient safety and the effectiveness of screening to identify problems that practitioners are not aware of or are not reporting.

Once there is a consensus among medical staff leaders about the benefits of a late-career practitioner policy, those medical staff leaders need to make their case to their colleagues. This can be done at both department and medical staff-wide meetings. Again, leaders should make the scientific case for screening at the outset of the discussions. From there, the medical staff can collaborate to address specific concerns, such as:

- What age is the right age to start screening?
- Who pays for the screening?
- Who will perform the screening?
- Who will address problems identified by screening?
- What measures may the medical staff take to accommodate impairments or other problems detected by the screening?

These all are issues of importance to practitioners, and the more input they have in addressing them, the more likely the policy will succeed. The solution to each of these issues can be tailored differently for different medical staffs. Medical staff leaders should take into account the feedback they receive from late-career practitioners themselves so that leaders know how best to support them.¹⁰⁶ Consulting with colleagues at hospitals that have already adopted a late-career practitioner policy can be helpful too.

106 Comm. on Occupational Health, *supra* note 11, at 1.

Finally, seek medical staff input on the screening itself before rolling out the policy. Health care professionals surveyed stated that the screening process should include “peer review, practice evaluation, and assessments of physical and mental health, including a cognitive screening process.”¹⁰⁷ While these individualized components of review are important, medical staff leaders also should focus on the science and effect of aging on physical and cognitive functions. The findings from studies showing potential for decline in cognitive function and dexterity can be used to support both the BFOQ argument to avoid liability under the ADEA and to establish the exams are job related and consistent with business necessity as required by the ADA. Once a consensus has been reached on the content of the screening, the medical staff is ready to implement the late-career practitioner policy. Having engaged the medical staff throughout the process of developing the policy facilitates the implementation. That said, it is beneficial to have medical staff leaders acting as spokespersons when the policy is announced. This is the time to return to the core message, which is the policy is designed to foster patient safety and that the institution is committed to working with practitioners to address any impairments that might be detected through screening.

CONCLUSION

Determining which health care practitioners pose a risk to the safety and care of patients is part of the duty of hospital medical staffs.¹⁰⁸ Hospital medical staffs should adopt policies and procedures that allow for proactive interventions to avoid situations that create reasonable concern that puts patients at immediate risk.¹⁰⁹

The screening of late-career practitioners enables hospital medical staffs to ensure that their patients are safe and receiving quality care while also allowing the medical staff to support their health care practitioners.¹¹⁰ While adopting late-career practitioner policies presents potential exposure under the ADEA and the ADA and similar state laws, these policies improve the medical staff’s ability to provide safe patient care and are, therefore, ultimately the safest way to treat the competing risks to patient safety and employee rights.

107 McDADE, *supra* note 4, at 4.

108 CPPPH, *supra* note 37, at 14.

109 Dickinson, *supra* note 32.

110 McDADE, *supra* note 4, at 12.

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