Assessing the Aging Physician: Reviewing the Findings of a Screening Battery Study

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Date: Tuesday, October 24

Time: 9:30 a.m. - 11:00 a.m.

Total CE Credits: 1.5

Presenter(s): David Bazzo, MD, FAAFP
Assessing the Aging Physician: Reviewing the Findings of a Screening Battery Study

David E.J. Bazzo, M.D.
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Director, Fitness for Duty, UC San Diego PACE Program

David E.J. Bazzo, M.D. has no relevant financial relationships to disclose that would present a conflict of interest.

DISCLOSURES
Objectives

- At the end of this activity, participants will be able to:
  - Describe the difference between a fitness for duty evaluation and an aging physician screen
  - Describe the components of an aging physician screening evaluation
  - Evaluate the results of a pilot study utilizing an aging physician screen.

The UC San Diego PACE Program

- Founded in 1996
- Provides assessment of physician competencies and remediation of deficiencies
- Competency assessment of more than 1750 physicians
- Educational services to more than 6000 physicians

What to measure?
The ACGME/ABMS 6 Core Competencies

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice
The PACE Fitness for Duty Program (founded 2011)

• Similar to the Competency Assessment, but it is intended for physicians for whom it is suspected that a physical, mental, or cognitive illness may be impacting competence and clinical performance
• Usually will include one or more generalist and/or subspecialty health evaluations
• May also include competency components and/or simulations, depending on the physician’s specialty and reason for referral

How the FFD Program Came To Be

• Robust health screening has always been part of the PACE competency assessment
  – The first 250 (or so) competency assessments included a complete neuropsychological evaluation and H&P exam
  – Eventually deemed excessive
• First 1200 (or so) competency assessments have included the MicroCog, self-report forms (PHQ-9, UCSD Family Medicine adult health history questionnaire), and a complete H&P
• Currently ~ 6-7% of competency assessments result in failure due to impairment (about 5-6 per year)

PACE FFD Program Processes

• First Step: Establish FFD, competency or combined
• Second Step: Who will receive results
• Third Step: Obtain background information from referring agency and physician:
  – Information requested from referring agency:
    • Reason(s) for referral in writing
    • Timeline of events
    • Job description if available and/or list of privileges
    • Any additional relevant information
PACE FFD Program Processes

- Information requested from physician:
  - Personal health records
  - Intake form
  - Adult Health Questionnaire
  - Patient Health Questionnaire (PHQ-9)
  - CV
  - Root cause analysis

PACE FFD Program Processes

- **Fourth Step:** Review background information to determine scope of FFDE
  - Comprehensive medical examination
  - Toxicology screen
  - Neuropsychological testing
  - Neuropsychological evaluation
  - Ophthalmologic evaluation
  - Neurologic evaluation
  - Specialty medical evaluations
  - Functional Assessment
  - Standardized procedures/skill evaluations in the physician’s specialty
  - Chart reviews
  - Oral examinations
  - 360-degree workplace survey

PACE FFD Program Processes

- **Fifth Step:** Schedule FFD evaluation
- **Sixth Step:** Review results and assign final grade
  - Clearly fit for all aspects of duty
  - Fit for some duties, but not others (fit with accommodations)
  - Unfit for duty
- **7th and Final Step:** Write final report summarizing all aspects of FFDE
AMA Masterfile: Physicians Past, Present and Future

- **1985**
  - Number in active practice = 476,683
  - Mean age = not known
  - % 65 or older = 9.4

- **2005**
  - Number in active practice = 672,531
  - Mean age = 50.0 (SD = 11.4)
  - % 65 or older = 11.7 (n = 78,340)

- **2014** (FSMB data)
  - Number in active practice = 916,264
  - Mean age = 52; 55 m, 47 f
  - % 60 or older = 30.9 (n = 282,472)
  - % 70 or older = 10.9 (n = 99,554)

- **2020**
  - Number in active practice = 1,050,000 (estimate)
  - % 65 or older = 18 (n = 189,000)
  - % 55 or older = 39 (n = 409,500)

Risk Factors Other Than Aging That May Affect Clinical Competence

- Poor performance in medical school
- Solo practice
- Lack of hospital privileges
- Lack of ABMS board certification
- Out-of-scope practice
- Clinical volume
- New knowledge/procedural skills
- Fatigue/stress/burnout
- Health issues—mental and physical—may or may not relate to aging

Responsibility: Societal/Professional Contract – 19th Century

As a self-regulated profession, medicine is granted substantial societal privilege and, in return, is expected to set standards for entering practice, for sustaining privilege to practice, and for sanctioning and removing from practice physicians (5%–10%) who neglect or abuse that privilege.
Responsibility

96% of physician responders agreed that impaired or incompetent physicians should be reported to the appropriate authorities.

45% reported that they had encountered such colleagues and failed to report incompetent colleagues.

“Normal” changes associated with aging

- Atrophy of brain
- Decline in number of brain neurons
- Benign senescent forgetfulness
- Decreased lean muscle mass
- Decreased visual acuity
- Diminished hearing
- Decreased reflex time
- Osteoporosis
- Arteriosclerosis
- Decreased compliance of arteries and left ventricle

Diseases associated with aging

- Myocardial infarction
- Stroke
- Most cancers
- Dementia
- Parkinson’s Disease
- Other neurodegenerative disorders
Petersen RC. Mild cognitive impairment
NEJM 2011; 364: 2227-34.

- In persons older than 65 in the general population the prevalence of mild cognitive impairment (MCI) is about 10% and perhaps slightly more.
- In the population with MCI the annual progression to dementia, most commonly Alzheimer’s disease, is about 5% to 10%.

Moutier CY, Bazzo DEJ, Norcross WA.

- Independent complete history and physical examination, to include screening vision and hearing.
- Assessment of mental health using inexpensive standardized tools.
- Cognitive assessment (Microcog or MOCA).
- Peer review (?).
- Goals would be safe patient care, quality improvement, maximizing physician health.
- If needed, accommodations where possible; including “winding down,” transitioning to retirement.

Comment

- Setting an age-based standard for cessation of practice makes no scientific sense.
- Humans age in a very heterogeneous way.
- To the extent we can measure such things, aging brings experience, compassion, and wisdom.
Unintended Consequences of Age-Based Competence Decisions/Mandatory Retirement

- Contribute to predicted physician shortfall as population ages and their needs for medical care increase
- Loss of contributions of medical wisdom and experience
- Economic losses: society paid for medical education; delaying retirement
- Beware the “law of averages”—old does not necessarily mean incompetent
- Age may be a risk factor, but it is not the only one
- Age Discrimination in Employment Act (ADEA)

California Public Protection and Physician Health Inc. (CPPPH)

- Funded by CMA, CHA, specialty societies, county medical societies, and professional liability insurance carriers.
- Mission Statement: “...to develop a comprehensive statewide physician health program so that California does not remain one of the few states without such a resource.”
- Outreach: Regional Workshops on “Neuropsychological and Psychological Factors” and “Legal Aspects” relating to Aging Physicians

AMA – 2015 Report: Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians

- “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.”
Recent review on the topic

- Ensuring Competent Care by Senior Physicians
- Hawkins, Richard E. MD; Welcher, Catherine M. BA; Stagg Elliott, Victoria MA; Pieters, Richard S. MD; Puscas, Liana MD, MHS; Wick, Paul H. MD

Journal of Continuing Education in the Health Professions: Summer 2016 - Volume 36 - Issue 3 - p 226–231

The Canadian experience: Quebec

- 2001–2010, 1,618 physicians were contacted 2 to 3 months in advance of an onsite visit in which their practice would be reviewed.
  - Level 0: No action, satisfaction letter
  - Level 1: Recommendations
  - Level 2: Recommendations and control visit follow-up
  - Level 3: Refresher course or retraining or limitation (retirement was a frequent option with this result)
  - Level 4: Cancellation of licensure

- Physicians over the age of 70 had three times higher rate of cancellation (31 percent) compared to the group less than 70 years old (10 percent).
- 65 to 69 showed only slightly higher rate of cancellation (13 percent) but had nearly double the rate of Level 3 recommendation than for the physician group less than 65 years old (18 percent vs. 10 percent).

The Canadian experience: Ontario

- 22% of physicians in the group over 75 years old had gross deficiencies in their practice
- 16% in the 50-to-74 year-old group had deficiencies
- 9% of physicians under the age of 49 had deficiencies

- When the age categories were split differently:
  - 55-and-older physicians had poorer performance than physicians under age 55
  - Surprisingly, there was close to no difference in physicians’ performance outcomes between the 55-to-69 year-old group and the group over 70 years old.
Screening Test vs. Diagnostic Test

Screening tests are offered to asymptomatic people who may or may not have early disease or disease precursors and test results are used to guide whether or not a diagnostic test should be offered.

<table>
<thead>
<tr>
<th>Hospital/Group</th>
<th>Screening Commences At</th>
<th>Frequency of Assessment</th>
<th>Areas Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Virginia Health System</td>
<td>Age 70</td>
<td>Every year after age 75</td>
<td>Physical and mental capacity (not defined further)</td>
</tr>
<tr>
<td>Munson Healthcare (Michigan)</td>
<td>Age 65, then 75</td>
<td>At requirement</td>
<td>Physical and mental examinations</td>
</tr>
<tr>
<td>St. Jude Children’s Hospital</td>
<td>Age 70</td>
<td>At requirement</td>
<td>Physical and mental evaluations</td>
</tr>
<tr>
<td>Sharp Rees-Steely (San Diego, CA)</td>
<td>Age 70</td>
<td>Every year after age 70</td>
<td>Mental Health (e.g., MMSE, H&amp;P, vision, hearing, substance use disorders, depression and anxiety)</td>
</tr>
</tbody>
</table>

Overall Rationale for PACE Aging Physician Assessment (PAPA)

- Reliable
- Easy
- Inexpensive
- Broad Acceptance

Screening Battery

- Cognitive screen
  - MicroCog™
  - MacAud
- Intake form
  - e.g. PACE, 87 questions
- History & physical exam
- Vision, hearing
- Screen for substance abuse, depression and anxiety
  - PHQ-9
  - GAD-7
- Simulators, dexterity testing (peg board, suturing)

Rationale for MicroCog™

- Designed for physicians
- Norm groups based on education level
- Data comparison between age-based norms and general populations

***Quality data:*** OPPE (Ongoing Professional Practice Evaluation), FPPE (Focused Professional Practice Evaluation), peer review, proctoring.
Participants

PAPA Participant Practice Status by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Retired</th>
<th>Practicing</th>
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</thead>
<tbody>
<tr>
<td>50-59 (n=5)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>60-69 (n=9)</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>70+ (n=16)</td>
<td>12</td>
<td>4</td>
</tr>
</tbody>
</table>

Results of cognitive testing: MicroCog™

Outcome Based on PAPA Participant MicroCog™ Scores

- Needs Further Evaluation (n=7)
- Does Not Need Further Evaluation (n=22)
- May Need Further Evaluation (n=3)

MoCA® vs. MicroCog™

PAPA Participant MoCA® Scores

<table>
<thead>
<tr>
<th>MoCA® Score</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>26</td>
<td>2</td>
</tr>
<tr>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>30</td>
<td>13</td>
</tr>
</tbody>
</table>
Practicing doctors who needed further evaluation

*Based on MicroCog™ results

PAPA Participants with recommendations for further evaluation and may need further evaluation by practice status (n=8/30)

- 25% Practicing (n=6)
- 75% Retired (n=2)

Age group recommendations

*Based on MicroCog™ results

Number of PAPA Participants with Recommendations for Further Evaluation and May Need Further Evaluation by Age Group

- 1 50-59
- 1 60-69
- 1 70+
- 5 Total

Participant comments

- What was their opinion of the process?
- Should this type of screening be applied universally?
## PAPA Comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Good Process/thorough</td>
<td>23</td>
</tr>
<tr>
<td>Universal screening</td>
<td>14</td>
</tr>
<tr>
<td>Service</td>
<td>6</td>
</tr>
<tr>
<td>Surgical field/procedure/simulator</td>
<td>5</td>
</tr>
<tr>
<td>Age-based screening is critical</td>
<td>5</td>
</tr>
<tr>
<td>Retesting in future</td>
<td>4</td>
</tr>
<tr>
<td>Beneficial</td>
<td>3</td>
</tr>
<tr>
<td>Compulsory testing</td>
<td>3</td>
</tr>
<tr>
<td>Physician take lead vs. mandated process</td>
<td>2</td>
</tr>
<tr>
<td>Independent body do testing</td>
<td>1</td>
</tr>
<tr>
<td>MicroCog™ fun</td>
<td>1</td>
</tr>
<tr>
<td>Thankful for feedback</td>
<td>1</td>
</tr>
</tbody>
</table>

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## PAPA Comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer problems/didn't understand</td>
<td>5</td>
</tr>
<tr>
<td>Tests tedious/tiring during MicroCog™</td>
<td>5</td>
</tr>
<tr>
<td>Universal application touchy/over-regulated/not another hoop</td>
<td>1</td>
</tr>
<tr>
<td>Cost concern</td>
<td>1</td>
</tr>
<tr>
<td>Longer than expected</td>
<td>1</td>
</tr>
</tbody>
</table>

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## PACE Aging Physician Assessment - Data

- Started July 2014
- XX evaluations to date
  - X participants with 2 evaluations
  - X female – X participant with 2 evaluations
- Youngest XX
- Oldest XX
  - Average XX
**PAPA - data**

- Pediatrics – XX (X with two evaluations)
- Radiology – X
- Orthopedic surgery – X
- Urgent care – X
- Otolaryngology – X
- Internal medicine – X
- Plastic surgery – X

*All but X board certified

**X screens with recommended further evaluation**

- X with full neuropsychological assessment
  - X found Fit
  - X found Unfit
- X pending full neuropsychological assessment

**Screening location?**

- **Home institution**
  - Advantage: close, control of process
  - Hurdle: bias, resources
- **Local/regional center**
  - Advantage: relatively close, standardized
  - Hurdle: loss of control, cost
- **National center**
  - Advantage: standardization, study
  - Hurdle: cost, distance
Accommodations

- Can a surgeon with early mild cognitive impairment first-assist at surgery?
- What if something bad happened and that became generally known, even if it were not the surgeon’s fault?

Accommodations: Severe hearing loss

- In a pediatric cardiologist in 1950?
- In a pediatric cardiologist in 2015?

Criticisms of age-based physician screening and assessment

- Tools and processes used have not been directly tested on physicians in a controlled, prospective trial
- It is unclear who will do the screening
- It is unclear who should “own” the results
- The motivation of the assessors or those ordering the assessment may not always be pure
- The assessors or those ordering the assessment may not have clear plans for how to manage the results
Questions

Thank you
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RESOURCE PACKET
RELATING TO THE ISSUE OF
THE LATE CAREER PHYSICIAN

Contents:

1. "ORGANIZATIONAL PORTFOLIO" including:
   a. List of Related PACE Faculty
   b. Articles and Publications
   c. List of Presentations
   d. Links to Video Lectures
2. SAMPLE QUESTIONNAIRE used by a client to survey medical staff opinion
3. SAMPLE POLICIES:
   • Driscoll Children's Hospital
   • University of Virginia Health System
4. AMA 2015 REPORT entitled “Competency and the Aging Physician”
UC San Diego PACE Program

Organizational Portfolio on the Topic of Physician Aging

Updated April 16, 2014

Faculty

William Norcross, M.D.
Clinical Professor of Family Medicine
Director, UC San Diego PACE Program

William Perry, Ph.D.
Professor, Department of Psychiatry
University of California, San Diego
Associate Director of Neuropsychiatry and Behavioral Medicine

David E.J. Bazzo, M.D., FAAFP
Clinical Professor of Family Medicine
University of California, San Diego, School of Medicine
Director, UCSD C-CHIP Program
Director, UCSD PACE Program Fitness for Duty Program
Co-Director, Primary Care Core Clerkship

Stephen Miller, M.D.
Voluntary Clinical Professor of Surgery and Family and Preventive Medicine
UC San PACE Program
UCSD School of Medicine

Articles and Publications


2. In early 2011, Dr. Norcross was included in a NYT article entitled "As Doctors Age, Worries About Their Ability Grow". (http://www.nytimes.com/2011/01/25/health/25doctors.html?_r=1&pagewanted=all)

3. Synergy Magazine (the official publication of the National Association of Medical Staff Services) has an article by Larry Harman, Ph.D., which describes the PACE Competence Assessment as a “Level 3” solution for evaluating aging physicians. (Volume 39, No. 5, September/October 2011)


10. Conference proceedings for the 2011 conference (below) were published in the Journal of Medical Regulation in 2013. This article received the “Federation of State Medical Boards Ray L. Casterline Award for Excellence in Writing” for 2013: http://jmr.fsmb.org/pdf/FeaturedArticles/jmr‐aging‐physicians.pdf


12. Dr. Norcross was featured in an article by Sara Stankorb for Proto entitled “Out of Practice: Does being a physician come with an expiration date? And if it should, how can age‐related competence be measured?” on June 10, 2015. http://protomag.com/articles/out‐of‐practice

13. Dr. Bazzo was featured in an article by Cheryl Clark entitled “Aging Doctors: Time for Mandatory Competency Testing?”, which was published on June 29, 2015 in Medpage Today. http://www.medpagetoday.com/PublicHealthPolicy/GeneralProfessionalIssues/52363

14. Drs. Bazzo and Norcross were featured in an article by Cheryl Clark entitled “Aging Docs: Contractor Offers Turnkey Assessment”, which was published on August 5, 2015 in Medpage Today. http://www.medpagetoday.com/PublicHealthPolicy/GeneralProfessionalIssues/52936

15. Dr. Bazzo was interviewed for “Midday Edition” on KPBS 89.5 and “Evening Edition” on KPBS TV in San Diego on August 18, 2015: “Hospitals, medical groups start to worry about skills of older doctors”. http://www.kpbs.org/news/2015/aug/18/hospitals‐medical‐groups‐start‐worry‐about‐skills‐/

**Presentations**
(Not including talks provided to hospitals and medical groups.)

1. In November, 2011, PACE hosted a conference that was themed on the aging physician on behalf of the Coalition for Physician Enhancement, which is a bi‐national association of programs similar to PACE. Attendees included attorneys, medical board members/staff, administrative law judges and other healthcare professionals.

For a pdf version of this document, please contact Katie Borton at kjborton@ucsd.edu.

- 2 -
professionals. Video footage of a good deal of this conference is available at out UCSD-TV page here: http://www.ucsd.tv/pace/.

2. Drs. Perry and Norcross, presented “Assessing the physician population: Psychological and Neuropsychological factors” to the California Administrative Law Judges on October 19, 2012. (Dr. Perry does Neuropsychological Evaluations for PACE Competence and Fitness for Duty Assessments.)

3. Dr. Perry presented to the Medical Board of California on January 31, 2013. The topic of the presentation was: “Assessing the Aging Physician: Neuropsychological and Psychological Factors Pertaining to Fitness for Duty”


6. Dr. Norcross presented “Senior Physicians and Competency and Physician Well-Being” to the Community Memorial Health System on Saturday, August 10, 2013.


9. Dr. Perry presented “Assessing the Aging Physician: Neuropsychological and Psychological Factors Pertaining to Fitness for Duty” to the California Medical Association Organized Medical Staff Section on October 10, 2013.


12. Dr. Perry presented “The Aging Physician” at the 2014 San Diego and Orange County California Association of Medical Staff Services Meeting on February 28, 2014.

For a pdf version of this document, please contact Katie Borton at kjborton@ucsd.edu.


18. Dr. Bazzo presented “Fitness, Competence, and Performance: Helping Physicians to Assure Patient Safety” to the annual National Association of Medical Staff Services Meeting on October 8, 2014.

19. Dr. Bazzo provided a presentation to the AMA Work Group on Assessment of Senior/Late Career Physicians convened by the Council on Medical Education in collaboration with the Senior Physicians Section to inform AMA upcoming policy on “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians (A-15)”
The aging physician:
Free sample aging physician questionnaire (sent to all medical staff by a hospital via SurveyMonkey)
For a pdf of this document, contact Katie Borton at kjborton@ucsd.edu.

1. My current age (this is the only demographic question you will be asked):
   A. Under 30
   B. 30 - 44
   C. 45 - 54
   D. 55 - 64
   E. Over 65

2. At what age do you think you will retire?
   A. No plans yet - too far in the future
   B. Before 65
   C. By 70
   D. By 75
   E. Never

3. Has the national economic downturn of 2008 changed your retirement plans?
   A. Yes
   B. No

4. Should the Medical Staff have a mandatory retirement age?
   A. Yes
   B. No

5. Proposed age for mandatory retirement from Medical Staff?
   A. by 65
   B. by 70
   C. by 75
   D. by 80
   E. by 85
   F. by 90

6. What is the most significant factor that might force you to retire "earlier" than you would like?
   A. Call responsibilities
   B. Personal health issues
   C. Family responsibilities
   D. Feeling like I cannot keep up and provide good care
E. Frustrations with where “health care” is going, locally or nationally
F. None of the above
G. Other (please specify)

7. Should the medical staff institute regular screening for age-related impairments in performance after a certain age?
   A. Yes
   B. No

8. What age should screening begin?
   A. by 60
   B. by 65
   C. by 70
   D. by 75
   E. by 80
   F. by 85
   G. by 90

9. What type of screening should be initiated?

10. Should the Medical Staff have a mandatory age to begin “fitness to practice” assessments?
    A. Yes
    B. No

11. Proposed age for mandatory “Fitness to Practice” Assessment
    A. before 65
    B. between 65-70
    C. between 70-75
    D. between 75-80
    E. between 80-85
    F. after 85
    G. Other (please specify)

12. Should the “fitness to practice” of procedural-based specialists be assessed any differently than those who rely on cognition alone?
    A. Yes
    B. No
    C. Other (please specify)

13. Does your specialty board have a Maintenance of Certification (MOC) program?
    A. I am required to participate (e.g., timed limited certification)
    B. I voluntary participate (e.g., even though I am “grandfathered”)
    C. I am “grandfathered” and choose not to participate
    D. No participation required
14. Is participation in your MOC program sufficient as a “fitness to practice” assessment?
   A. Yes
   B. No
   C. Other (please specify)

15. If a “fitness to practice” examination is given, who should provide it?
   A. Medical Staff Services
   B. Outside body
   C. Assurance Commission, the Joint Commission (or other government agency)
   D. State Medical Society
   E. Other (please specify)

16. The Ongoing Professional Practice Evaluation (OPPE) done as part of recredentialing is sufficient to assess “fitness to practice”.
   A. Yes
   B. Yes, but should be more frequent than every 9 months for physicians over a certain age
   C. No
   D. Other (please specify)

17. Extra Credit: The State of [xxxxxxx] has a specific test for drivers over a certain age to renew their drivers’ licenses
   A. True
   B. False

18. Extra Credit: By law commercial pilots are required to retire at what age?
   A. 55
   B. 60
   C. 62
   D. 65
   E. 67
1.0 KEY WORDS:
Medical Staff, Practitioners, Aging, Cognitive/Mental Status Exam, Credentials, Medical Executive Committee, Clinical Privileges, and Confidentiality

2.0 PURPOSE:
The objective of this policy is to assure that patient safety and quality are adequately supported by carefully assessing the capabilities, competencies (cognitive and technical/procedural) and health status (ability to perform privileges granted) of each practitioner who is granted privileges upon reaching the age of 70 and thereafter.

3.0 DOCUMENT HISTORY:

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision Number</th>
<th>Action Made On Document</th>
<th>Reviewed With No Changes (Date)</th>
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</thead>
<tbody>
<tr>
<td>3/2010</td>
<td>New Document</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.0 PERSONS AFFECTED:
Practitioners privileged through the Medical Staff.

5.0 STANDARD/POLICY STATEMENT:
It is the policy of the Medical Staff that the Credentials Committee and Medical Executive Committee specifically assess, on an ongoing basis, the capabilities, competencies and health status of each practitioner who is granted privileges in accordance with the Medical Staff Bylaws, Credentials Policy and other Medical Staff guidelines or procedures related to clinical privileging.
6.0 DEFINITIONS/RELATED INFORMATION:

6.1 Background:
In granting clinical privileges, the Medical Staff and Governing Board are required to assess the ability of each practitioner to safely and competently perform all requested privileges. As individuals age, both the natural aging process and specific medical conditions have the potential to adversely impact the capacity of a practitioner to perform some or all of the clinical privileges requested. Therefore, the Medical Staff and the Governing Board are obligated to establish an approach to evaluating the impact of aging on a practitioner’s capacity to perform requested clinical privileges in the facility.

Recognizing that there is no national consensus concerning the best approach to the challenge of aging practitioners, the Medical Staff adopts this policy in order to:

- Support physicians and other privileged practitioners
- Protect physician and other privileged practitioner rights
- Apply such evaluation criteria objectively, equitably, respectfully, and confidentially
- Strive to provide patients with a high level of clinical quality and safety and protect them from harm.

6.2 Practitioner: Includes everyone privileged through the Medical Staff.

7.0 PROCEDURE/GUIDELINE:

7.1 As a part of any application process for initial appointment or reappointment on or after the age of 70 or on request of the Credentials Committee, each practitioner requesting clinical privileges shall undergo and submit as a required element of his/her application the report of a comprehensive examination that addresses both physical and mental capacity to competently perform the clinical privileges requested.

- The physical and mental examinations will be conducted by a physician acceptable to the Credentials Committee, and the report(s) of such examinations must be in a format acceptable to the Credentials Committee.
- Suggested elements for such examinations will be identified by the Credentials Committee and may include psychological testing and assessment.
- It shall be the responsibility of the practitioner to arrange for the required evaluations and the submission of required reports, and the application for appointment or reappointment will be considered incomplete, and therefore will not be processed, until such reports of the required evaluations are received.

7.2 The examinations described in this policy constitute a “fitness for work” evaluation, and must indicate that the practitioner has no physical or mental problem that might interfere with the safe and effective provision of care permitted with the clinical privileges requested.

- Adverse findings that might interfere with the safe and effective provision of care with the privileges requested will be processed in accordance with the applicable Medical Staff procedure, including adherence to state and federally mandated reporting requirements.

7.3 In addition to the examinations described above, a practitioner may be required to undergo proctoring of his/her clinical performance as a part of the assessment of his/her capacity to perform requested privileges. Such proctoring may be required in the absence of any previous performance concerns.
• The scope and duration of the proctoring shall be determined by the Medical Executive Committee upon recommendation of the MSPI Committee, Department Chair and/or the Credentials Committee.

7.4 For any practitioner who will be age 70 or greater at the time of appointment or reappointment or who is otherwise requested by the Credentials Committee to undergo evaluation, the Medical Staff Services Office will notify the practitioner of the examinations required by this policy. The notification will include:

• The suggested elements of a screening evaluation (Appendix A) and a copy of the approved form (Appendix B) upon which the examination must be documented for reporting the results of such examinations
• The date that the results of the examination are due
• The fact that his/her application will not be processed until such reports are received, and that a delay in receipt may result in a lapse of Medical Staff membership and clinical privileges
• Notice that the required examinations must be performed by a physician acceptable to the Credentials Committee
• A copy of this policy
• A copy of the current clinical privileges held (or requested) by the practitioner

7.5 Confidentiality is of utmost importance. Details of the practitioner’s physical and mental status exam will remain in the custody of the practitioner’s physician. The practitioner’s examining physician is only required to provide a completed copy of the DCH approved form (Appendix B) as a report of the examination results. In order to maintain the confidentiality of the information obtained, upon receipt of the reports of examination results (Appendix B) the Credentialing Specialist will review the results with the Chairman of the Credentials Committee and the Chief of Staff.

• If findings do not identify potential patient care concerns, the results will be filed in a confidential file and the Credentials File will only reflect that the examination process has been completed with no significant concerns identified.
• However, if in the opinion of the above reviewers there are findings of potential concern, the information will be confidentially evaluated by the Credentials Committee.

7.6 If the conclusion of the Credentials Committee is that the practitioner has been unable to establish his capability to safely and competently perform the privileges requested, discussion with the practitioner should be undertaken by a representative of the Credentials Committee regarding alternative practice patterns or modification of requested privileges.

• The goal of such discussion is to be supportive and respectful of the practitioner, and to suggest resources to assist the practitioner.

8.0 REFERENCES:

8.1 Improving Patient Care; Systematic Review: The Relationship between Clinical Experience and Quality of Health Care. 2005 American College of Physicians. 260-273.

8.2 The aging physician: Balancing safety, respect, and dignity; Medical Staff Leader Connection, September 23, 2009.

8.3 Joint Commission
8.4 Americans with Disabilities Act

9.0 INTERNAL CROSS-REFERENCES:

9.1 Credential Policy
9.2 Physician Health Policy
9.3 Proctoring Policy
9.4 FPPE/OPPE Policy

10.0 ATTACHMENTS

10.1 Suggested Elements of a Screening Evaluation for Practitioners Age 70 and Older (Appendix A)
10.2 Screening Evaluation Report Form (Appendix B)
Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0294

A. SUBJECT: The Aging Practitioner (R)

B. EFFECTIVE DATE: July 1, 2012

C. POLICY STATEMENT:

The University of Virginia Clinical Staff is obligated to assess each member’s capacity to perform requested privileges. This policy establishes a procedure for assessing the impact of aging on that capacity.

D. DEFINITIONS AND PROCEDURE:

The term of clinical privileges for practitioners who are 69 years old will be set such that their privileges expire during the year they reach the age of 70.

1. The first time a practitioner applies for privileges after reaching the age of 70, he/she shall complete an examination that addresses both physical and mental capacity for the privileges requested. This exam shall be conducted under the auspices of the Physician Wellness Program. The results of this exam shall be forwarded to the practitioner’s Department Chair/Division Chief for his/her consideration and for inclusion with the other required privileging documents submitted to the Credentials Committee. If the Practitioner is a Department Chair, the Dean of the School of Medicine shall take the place of the Department Chair for purposes of this Policy.

2. After reaching the age of 75, practitioners holding clinical privileges shall complete an annual examination that addresses both physical and mental capacity for the privileges requested. This exam shall be conducted under the auspices of the Physician Wellness Program. The results of this exam shall be forwarded to the practitioner’s Department Chair/Division Chief, or, as applicable, the Dean of the School of Medicine, for his/her consideration and for inclusion with the other required privileging documents submitted to the Credentials Committee. The standard term of clinical privileges shall be one year for practitioners 75 years of age or older (privileges must be renewed annually once a practitioner reaches age 75).

3. The Department Chair/Division Chief, or where applicable, the Dean of the School of Medicine, must also indicate approval of the requested privileges through his/her signature on the privileging application. The physical and mental capacity examination described above is an adjunct to, not a substitute for, appropriate consideration by the Department Chair/Division Chief/Dean regarding the practitioner’s capacity to provide the specialty specific clinical services for which privileges are requested. Both documentation of the examination and
(SUBJECT: The Aging Practitioner)

approval of the Department Chair/Division Chief, or, as applicable, the Dean, are required for an application to be considered by the Credentials Committee.

SIGNATURES:

Robert S. Gibson, M.D., President Clinical Staff
R. Edward Howell, CEO, UVA Medical Center

DATE:

Medical Center Policy No. 0294 (R)
Approved July 2011
Revised June 2012
Approved by Credentials Committee
Approved by Clinical Staff Executive Committee
EXECUTIVE SUMMARY

The increasing numbers of older physicians, as well as the call for increased accountability by the public, have led regulators and policymakers to consider implementing some form of age-based competency screening of physicians. All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard, and older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician’s competence can be highly variable. In response to Policy D-275.959, Competency and the Aging Physician, this report explores whether there is a need to establish guidelines for the testing for and judgment of an aging/late career physician’s competence to care for patients.

The literature shows that assessment of practicing physicians is challenging because there are a limited number of valid tools that may be applied to measuring competence and/or practice performance; other challenges include the variable nature of physician practices and cultural resistance to externally derived assessment approaches. Assessment of aging physicians poses unique challenges related to the uncertain and variable influence of aging on clinical competence and performance in practice. In addition, policy decisions regarding assessment of older physicians must balance the higher index of concern regarding potential competence deficits due to the effect of aging on physical health and cognitive function with a need to avoid implementation of discriminatory regulatory policies and procedures. Although age is a factor in predicting the prevalence of dyscompetence, other individual and practice factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc. Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.

It is part of a physician’s professional duty to continually assess his or her own physical and mental health, as well as report all instances of significantly impaired or incompetent colleagues to hospital, clinic or other relevant authorities. Contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and new and evolving maintenance of certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

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. It should be noted that the development of guidelines/standards for appropriate mechanisms to assess aging/late career physicians will require significant resources, and would have to be consistent with state regulations at a number of levels.
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-15

Subject: Competency and the Aging Physician

Presented by: William A. McDade, MD, Chair

Referred to: Reference Committee C
(Daniel B. Kimball, Jr., MD, Chair)

Policy D-275.959, Competency and the Aging Physician, directs our American Medical Association (AMA) to: 1) study the issue of competency in aging physicians and develop guidelines, if the study supports such a need, for appropriate mechanisms of assessment to assure that America’s physicians remain able to provide optimal care for their patients; and 2) report back to the House of Delegates.

INTRODUCTION

The process of becoming a practicing physician in the United States requires a substantial commitment of time, money, energy, and emotion on behalf of each physician. Throughout their careers, physicians are recognized as professionals who practice a complex “craft” which requires them to maintain their skills and education, as well as make difficult, often quick and sometimes life-and-death decisions that demand high and complex levels of cognitive functioning. 1, 2 The state medical boards grant physicians the authority to provide services that other health care professionals cannot provide.

As the demands of medical practice and the quantity of patients continue to grow, older physicians remain an essential part of the physician workforce. 3 The total number of physicians 65 years and older more than quadrupled from 50,993 in 1975 to 241,641 in 2013. Physicians 65 and older currently represent 23 percent of physicians in the United States. Within this group, two-fifths (39.3 percent) are actively engaged in patient care, while half (54 percent) are listed as inactive in the AMA Physician Masterfile. 4 The increasing numbers of older physicians, as well as the call for increased accountability by the public, have led regulators and policymakers to consider implementing some form of age-based competency screening. 5 All physicians must meet state licensing requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard, and older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. 6, 7

Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician’s competence can be highly variable. 8 Many issues affecting late career physicians also affect those with a lapse in practice; assessment and remediation services for these physicians may be similar. However, there is a distinction between those seeking to reenter practice and the aging/late career physician. This report explores whether there is a need to establish guidelines for the testing for and judgment of an aging/late career physician’s competence to care for patients.
DETERMINING IF AN OLDER PHYSICIAN IS CLINICALLY COMPETENT

Assessment of practicing physicians is challenging because of the limited number of valid tools that may be applied to measuring competence and/or practice performance, the variable nature of physician practices, and cultural resistance to externally derived assessment approaches.

Assessment of aging physicians poses unique challenges related to the uncertain and variable influence of aging on clinical competence and performance in practice. In addition, policy decisions regarding assessment of older physicians must balance the higher index of concern regarding potential competence deficits due to the effect of aging on physical health and cognitive function with a need to avoid implementation of discriminatory regulatory policies and procedures.

A large body of research demonstrates that cognitive dysfunction is more prevalent among older adults, although aging, per se, does not necessarily result in cognitive impairment. Wide variations are seen in cognitive performance with aging, and the ability to clearly demonstrate an association between specific cognitive deficits and physician occupational performance is challenging. Furthermore, some attributes relevant to health care—such as wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of aging.

In terms of specific research findings that may have a significant impact on patient care, there is a tendency for physicians to rely more on non-analytic processes (such as pattern recognition and “gist”-based processes), as opposed to more active and controlled processes, as they age. With aging, fluid intelligence (“mental efficiency”) decreases while domain-specific, experientially-based knowledge remains stable. Non-analytic processes may lead to more accurate diagnoses by experienced physicians, particularly when based primarily on contextual information, but may result in unrecognized diagnostic errors when analytic processes cannot intervene during evolving or complex clinical situations. This may result in premature closure and diagnostic errors, and a compromise in the ability to care for more complex patients. Eva described several factors associated with aging that may either negatively impact the accuracy of non-analytical approaches or limit the ability to engage in analytical processes. These factors include:

- Decreasing working memory and the ability to store and process information;
- Decreasing processing speed of mental operations limiting the ability to complete complex tasks;
- Increasing difficulty in inhibiting irrelevant information and inappropriate responses, including the tendency to be overly influenced by the order in which information is received (primacy effect) and to be biased by personal experience; and
- Declining hearing and visual acuity, which in and of themselves may significantly contribute to age-related intelligence decline.

In addition to cognitive effects, relevant to maintenance of procedural competence, research shows that manual dexterity and visuospatial ability decrease with age.

Related to the influence of aging on the actual assessment of physicians, published data demonstrate a negative impact of increasing age on physician assessment results. Physician performance on knowledge examinations declines as a function of aging regardless of whether the examination assesses general medical or surgical knowledge or more practice-specific knowledge, such as blood product transfusion or emergency contraception. Important differences in performance may become more apparent after age 60. Although most physicians over age 60 will score significantly lower than their younger colleagues, higher variability among older test-takers results in some physicians over 60 performing as well as those younger than 40. Research
suggests that the lower score obtained by older physicians represents failure to acquire new or changing knowledge rather than the loss of their more stable knowledge base. Among physicians referred to an assessment center because of concerns regarding their clinical competence, older age and lack of board certification predicted a lower score on a computer-based clinical simulation designed to assess patient management skills. Detection of competence deficits among referred physicians is associated with an increased risk of underlying cognitive dysfunction, which may be more pronounced in elderly physicians.

When broader, multifaceted assessment approaches are deployed (including chart-stimulated recall, standardized patients, multiple-choice question tests, and oral examinations), physician age and time since graduation predict overall poorer performance. Of note, performance deficits may be identified across multiple competence domains such as history taking, physical examination and communication skills, problem solving, patient management, and record keeping. The negative impact of aging on performance was seen in both physicians referred for assessment because of concerns about their competence and in the physicians who served as a normative criterion (comparison) group. Data from the Peer Assessment Program in Ontario show that detection of gross deficiencies increases with age, occurring in nine percent of physicians under age 49, 16 percent of those ages 50 to 74, and 22 percent over age 75. In a sample of physicians referred from U.S. licensing authorities, assessment outcomes of older physicians are significantly more likely to be interpreted as unsafe for clinical practice. A neuropsychological analysis of physicians receiving adverse actions by a state medical board identified deficits in attention, sequential processing, logical analysis, eye-hand coordination, and verbal and non-verbal learning.

The relationship between the results from competence assessment and the eventual quality of care provided and patient outcomes is complex and does not necessarily allow for predictions at the individual practitioner level. Consistent with the research cited above showing declining knowledge and failure to acquire new knowledge over time, research shows that older primary care physicians are less likely to prescribe appropriate medications or incorporate new treatment strategies into their practices. A review of 62 studies found that increasing years in practice is associated with decreasing knowledge; lower adherence to evidence-based standards of care for diagnosis, prevention and treatment; and worse patient outcomes. A large majority (73 percent) of the studies showed an age-related decline in all or some of the parameters assessed, while only four percent showed an age-related improvement in all or some of the parameters assessed. Another study demonstrated that inpatients cared for by physicians who were practicing longer had longer stays and higher mortality rates. The peer review program in Ontario found age to be an independent predictor of poor quality of care and record keeping. In the United Kingdom, physician practices that are consistently classified as poorly performing relative to their quality and outcomes are more likely to be staffed by elderly general practitioners. However, not all research finds a negative association between age and quality. A large study of physician performance in Massachusetts, using publicly available claims data, did not find a relationship between quality and years of experience.

Research on actions taken by state medical boards suggests that advancing age is a risk factor for adverse licensing actions, although malpractice incidents and claims may occur less frequently among older physicians. Following a thorough practice review by Quebec licensing authorities, including medical record audit and assessment of prescribing habits and practice outcomes, physicians over age 70 were three times more likely to have their license cancelled than those under 70 years old, and were half as likely to successfully remediate. Physicians ages 65 to 97 were three times more likely to have inadequate continuing professional development (CPD) activity compared to their younger colleagues.
Studies have shown that aging in surgeons is associated with increased morbidity and/or mortality in patients undergoing thyroidectomy, carotid endarterectomy, knee replacement surgery, and coronary artery bypass grafting. A study based on Medicare data found that older surgeons, particularly those with low procedural volumes, have higher mortality rates for selected procedures, such as segmental colon resection, pancreatectomy, and CABG, but not for other complex procedures such as lung resection or abdominal aortic aneurysm repair. Older surgeons are less likely to integrate new modalities and recommendations for care into their practices; for example, they are less likely to perform breast reconstruction when indicated in breast cancer patients and are more likely to have delayed adoption of and higher complications with laparoscopic techniques.

OTHER FACTORS THAT AFFECT CLINICAL PERFORMANCE

Although age is a factor in predicting the prevalence of dyscompetence, there are other individual and practice factors that may influence performance. Physicians in solo practice (who have less contact with physician colleagues) and those who are in administrative positions (who have less patient contact) tend to score lower on knowledge-based examinations. Physicians in solo practice score lower on knowledge examinations related to both the loss of stable knowledge and failure to acquire new and changing knowledge, suggesting that an isolated environment impacts one’s abilities to maintain and acquire knowledge. Broad, multifaceted assessment approaches identify solo practice, international training, lack of board certification, general practice and incongruence between training and scope of practice as additional risk factors predicting poor performance outcomes. Board certification, female gender, and graduation from a domestic medical school, but not time in practice, were associated with better quality of care as identified by review of claims data in Massachusetts. Similarly, the peer assessment program in Canada found that, in addition to increasing age, lack of board certification, male gender, and a rural practice location were associated with worse quality of care and documentation in the medical record. Furthermore, multivariate analysis revealed a related and potentially additive impact of age, practice location, and lack of certification. In addition, male gender, lack of board certification or hospital privileges, graduation from a foreign medical school, high clinical volume, physical and mental health issues, and certain specialty practices are also risk factors for adverse licensure action. Of note, self-reported continuing medical education (CME) hours may be directly correlated with incompetence. Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.

HEALTH SCREENINGS FOR PHYSICIANS

Moutier suggests that aging is but one of several risk factors for competence and performance problems and that a mandatory retirement age for physicians is not justified. However, Moutier gives credit to hospitals and medical systems that have initiated age-based screening processes, and a broad professional initiative in developing age-based screening policy and procedures is recommended. The majority of individuals surveyed during a conference of the Coalition for Physician Enhancement favored implementation of age-based screening of physicians’ competence. Among the respondents, which included staff from physician assessment centers, attorneys and state medical board members, 72 percent recommended that screening begin at age 65 or 70. Conference participants suggested the process should include peer review, practice evaluation, and assessments of physical and mental health, including a cognitive screening process.
Physicians’ Professional Responsibilities

It is part of all physicians’ professional duty to continually assess their own physical and mental health. Currently, there is no national standard for screening physicians who have reached a certain age. In addition, the standards of professional behavior authorized and adopted by medical societies state that physicians’ professional responsibilities should include reporting all instances of significantly impaired or incompetent colleagues to hospital, clinic or other relevant authorities.

Peer Review and Practice Evaluation

Although individual peers reporting on each other is the prime mechanism for identifying physicians whose knowledge, skills, or attitudes are compromised, and most physicians agree that impaired or incompetent physicians should be reported to the appropriate authorities, this method is not always reliable. A study by Campbell et al. showed that 45 percent of those with direct personal knowledge of a physician in their hospital group or practice who was impaired or incompetent did not always report that physician. Contemporary methods of self-regulation (e.g., clinical performance measurement; CPD requirements, including novel performance improvement, CME programs; and new and evolving maintenance of certification programs) have been created by the profession in part due to increasing recognition that sole reliance on individual physicians to report colleagues’ performance, even if it were 100 percent reliable, still would not be enough to meet shared obligations for quality assurance and patient safety.

From a public protection perspective, the objective assessment option seems like an important intervention, given the strong impact of aging on performance, the extreme variability of cognitive function among older physicians, and the well-documented inability of physicians to self-assess, in particular those who are less competent. Eva advised caution regarding the above interventions, with significant resource and administrative implications; they should not be universally mandated but implemented through a case-by-case, assessment-driven process, given the extreme variability of cognitive findings among older physicians. External, objective assessment also seems essential given that non-analytic processes may be even less accessible to critical self-appraisal than the more conscious analytical processes.

The Joint Commission’s Requirements

The Joint Commission’s standard MS.11.01.01 is specifically written to encourage medical staffs to identify and manage matters of individual health for licensed independent practitioners that are separate from actions taken for disciplinary purposes. The standard focuses on the education of physicians to recognize issues in others and also encourages self-referral in an effort to facilitate confidential diagnosis, treatment and rehabilitation by assisting a practitioner to retain and regain optimal professional functioning consistent with the protection of patients. If it is determined, however, that a physician is unable to exercise safely the privileges that he or she has been granted, The Joint Commission’s standard calls for the matter to be reported to the medical staff leadership for appropriate corrective action.

Hospital/Health System Screening Programs

A growing number of hospitals and health care systems have adopted official policies that require physicians to undergo health assessments upon reaching a certain age in order to examine practice patterns and physician abilities to practice safely. Examples of hospitals and groups that have such policies in place include the University of Virginia Health System, Driscoll Children’s Hospital in Texas, and Stanford Lucille Packard Children’s Hospital in California. The University
of Virginia screens physicians at age 70 and every year after age 75 and assesses physical and mental capacity. Driscoll screens physicians at age 70 and at reappointment thereafter, conducts physical and mental examinations and, if deemed appropriate, proctors clinical performance. Stanford screens physicians at age 75 and every two years thereafter, and screening includes peer assessment of clinical performance, history and physical assessments, and cognitive screening.\textsuperscript{52,53}

**US and Canadian Local Screening Programs**

LifeGuard, conceptualized and supported by the Pennsylvania Medical Society, evaluates and assesses the neurocognitive status, physical status, and medical knowledge of referred physicians and provides an objective report describing assessment results and recommendations for remediation (if applicable).\textsuperscript{54} LifeGuard is a resource for state medical boards, hospitals and health systems, medical staff, peer review boards, credentialing committees, physician group practices and physicians in Pennsylvania. The program includes the Aging Physician pathway for entities and organizations that need “ability to perform” assessments for senior physicians. This pathway measures clinical skills and health status; core components of the assessment can include an objective measurement of cognitive and physical functioning as well as fine motor skills. Additional assessment options are available based on the concerns identified by the requesting entity.\textsuperscript{54}

The Colorado Physician Health Program (CPHP), governed by the Colorado Peer Assistance Act, is independent of other medical organizations and the state government. The Denver Medical Society, the Colorado Medical Society and Copic Insurance Company were instrumental in establishing CPHP and continue their support of the program. CPHP provides confidential services in all areas required by law or regulation, including comprehensive clinical evaluation; treatment planning and referral; treatment monitoring and support; assessment of ability to practice safely; consultation to hospital administrators, medical executive committees and medical staff offices; education presentations on physician health and related issues; documentation of health status necessary for hospital credentialing; and neutrality, objectivity and confidentiality in the context of working with hospitals, partnerships, the Colorado Board of Medical Examiners, organizations, families and other systems with which the physician is involved.\textsuperscript{55}

The California Medical Association, California Hospital Association’s Center for Healthcare Medical Executives, and California Public Protection and Physician Health drafted guidelines and principles for medical staffs, medical groups, and other entities in California that have responsibility for decisions related to evaluating a practitioner’s health and well-being as they impact the practitioner’s ability to practice medicine safely. The draft guidelines include options for assessing physicians who choose to work late into their careers. The draft guidelines, available at https://cppphdotorg.files.wordpress.com/2011/02/assessing-late-career-practitioners-draft-26-wo-cma-1-14-15.pdf, are subject to periodic review and revision to incorporate new developments.

The College of Physicians and Surgeons of Ontario (CPSO) has established a formal system for assessing all physicians in Ontario. Duties of the College include issuing certificates of registration to doctors for the practice of medicine, monitoring and maintaining standards of practice through peer assessment and remediation, investigating complaints about doctors on behalf of the public, and conducting discipline hearings when doctors may have committed an act of professional misconduct or may be incompetent. Ontario physicians who reach age 70 are required to participate in the College-appointed peer assessment program (if the physician has not been randomly selected in the previous five years). These physicians are then assessed every five years thereafter. When a physician is selected to undergo assessment, a number of pre-assessment activities take place. Reviewing a physician’s medical record-keeping system is perhaps most often associated with peer
assessment. A records review enables an assessor to develop a picture of the physician’s practice and an understanding of his or her approach to patient care. Through the records review and discussion with the physician, assessors try to put together the “story of the patient.” An assessor evaluates the physician’s ability to take adequate histories, conduct appropriate examinations, order the necessary diagnostic tests, identify the appropriate course of action, conduct the necessary interventions and monitor patients, as necessary.6

FACTORS THAT MAY HAMPER ASSESSMENT OF OLDER PHYSICIANS’ COMPETENCE

Factors that may make assessment of older physicians more challenging include the variability of cognitive dysfunction in older adults, uncertainty regarding how to interpret tests of cognitive or motor function in physicians, the confounding effects of other variables on physician competence and performance, and the uncertain predictive value of specific competence assessments on the actual quality of care and patient outcomes.

With regard to measurement of cognitive dysfunction, it is uncertain whether and how physician results should be compared to the general population and whether their results should be age-matched for interpretation purposes.22 The nature of physician decisions, in terms of their difficulty, acuity and gravity, suggests that even minor changes in cognitive function may be impactful in patient care situations.2,27 Results for cognitive testing that are interpreted as normal based on comparison to an age-matched, non-physician population could potentially represent a significant decline in highly intelligent individuals.58,59 Turnbull and colleagues found that using an age-independent standard for neuropsychological performance was more sensitive in detecting cognitive problems among referred physicians, and it was more accurate in predicting assessment and remediation outcomes.23

Although there are currently no accepted criteria or guidelines for making judgments regarding acceptable cognitive or neuropsychological thresholds, there is a sentiment that public protection goals dictate the need for a high standard in judgments about cognitive ability in physicians.58 Should “corrections” be made in expectations for cognitive performance when they are not made for performance on other assessment modalities, such as the multiple-choice question examinations?22,23 Regardless of whether correction should be made for age-matching on physicians, the ultimate relationship between tests of cognitive function on clinical performance and outcomes is not well established.60 Caulford notes that the failure to assimilate new knowledge identified in the American Board of Internal Medicine (ABIM) studies is not clearly related to physician performance problems.26 Waljee points out that there is no evidence directly linking age-related decline in motor and visuospatial skills to worsening outcomes for patients.17 In fact, commonly used diagnostic assessments that focus primarily on analytic approaches to clinical care may yield somewhat spurious findings in physicians who rely more on non-analytical approaches.9 Yet, the identified relationship between cognitive performance level and prediction of assessment and remediation outcomes cannot be ignored.23

An increasingly prevalent perspective emerging from the CME community is the need to recognize the important influence of the system and practice environment on physicians in terms of their ability to learn and apply their learning in improving patient care and outcomes.61 Physician performance in practice represents a complex interaction between personal characteristics of the physician (age, gender and certification status) and practice context (practice structure, location, workload and patient acuity). This suggests that competence or performance assessment models should take into consideration the broader environmental context in which a physician practices.28,62 In fact, regression modeling suggests that incorporation of organizational and system factors substantially reduces the independent impact of age and other individual physician
characteristics on practice-based assessments of physicians. Durning and colleagues applied situated cognition theory as a framework for understanding how a physician’s thoughts and actions cannot be separated from the social context in which they practice. In addition to physician factors such as age and cognitive function, patient factors (acuity and complexity) and practice factors (appointment lengths, setting, staffing and support systems) affect a physician’s practice and influence patient care and outcomes. This phenomenon limits the ability of measures of cognitive function and knowledge, and perhaps measurement of other domains in an assessment center context, to explain or predict performance in the physician’s actual practice setting. 

Interpretations and decisions based on diagnostic assessment of clinical competence are also challenged by the lack of clear standards for physician performance and an overall lack of normative assessment data on practicing physicians. Even though physicians may be at increased risk for competence deficits as they age, the majority of older physicians most likely provide safe and effective patient care. While age is a risk factor for cognitive dysfunction among referred physicians, age in the absence of identified cognitive deficits does not necessarily have a negative impact on assessment or remediation outcomes. The challenge is to devise a process that will be cost effective in identifying physicians who require remediation, or perhaps should retire from practice. Norman and colleagues suggest a process analogous to an epidemiologic approach to screening for a low prevalence disease in which a single testing method may not be cost effective. A multifaceted approach would begin with an economical screening test with high sensitivity, followed by a more comprehensive diagnostic approach for those who are identified as a high risk for dyscompetence. The diagnostic approach would need to include assessment methods that cover the range of competencies relevant to safe and effective patient care, as physicians who are diagnosed as “incompetent” may have deficiencies that span more than one competency domain.

There remains some uncertainty about the value of results based on assessment of physician knowledge and skills in vitro for predicting their clinical performance and quality of care in vivo. It is difficult, in an assessment center setting, to account completely for practice and patient-related contextual factors that have a strong influence on physician performance. Work by Rethans and Kopelow suggests that physician behaviors in an assessment context may not accurately represent their actual clinical performance. On the other hand, there are consistencies noted between assessment outcomes and practice performance results. For example, assessment of aging physicians demonstrates their failure to acquire new or changing knowledge over time, and clinical studies show they fail to integrate new clinical information or methods in their practices. In response to potential concerns regarding relevance and predictability of competence assessments for actual performance in practice, the Physician Review Program (PREP) of the CPSO included medical records from physicians’ actual practice and standardized patient-simulated cases typical of those seen in physicians’ specific practice context. It would seem appropriate, pending resolution of such questions by targeted research, to integrate methods focusing on assessment of knowledge and skills with those assessing actual clinical performance in a way that is sensitive to practice context.

IMPAIRED PHYSICIANS AND UNIFORM WAYS TO DEAL WITH THEIR COMPETENCE TO PRACTICE

The profession of medicine holds itself to the high ideals of caring and competency; the first tenet is *primum non nocere* or “first do no harm.” Ethical guidelines state, “When health or wellness is compromised, so is the safety or effectiveness of the medical care provided. 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.”
Concern regarding the continuing competence of physicians has grown in recent years from the Institute of Medicine reports on patient safety as well as public concern with medical errors and inadequate practice oversight. Unlike commercial airline pilots who must undergo regular health screenings starting at age 40 and must retire at age 65, or FBI agents whose mandatory retirement age is 57, physicians are subject to no such rules.\textsuperscript{66,67} However, physicians are regulated by state medical boards, professional organizations, hospitals, organized systems, and specialty certification boards.

The issue of who holds physicians accountable to a high standard of practice throughout their careers is one that has troubled licensing authorities, hospitals and clinical directors, as well as third party payers. The primary purpose of state medical boards is to protect the public by ensuring that those who practice medicine are able to do so safely. In most states, relicensure, the process by which physicians renew their licenses to practice, consists primarily of reporting CME activities and maintaining a record free of violation of legislative and professional statutes and guidelines.\textsuperscript{67}

Hospitals have an obligation to retain only competent physicians on their staff. Some hospitals now require physicians over a certain age, usually starting between ages 70 to 75, to undergo periodic physical and cognitive exams as a condition of renewing their privileges. Other hospitals oppose setting a hard-and-fast-number for mandatory testing.\textsuperscript{5,68} The Joint Commission has established guidelines for ongoing evaluation of the professional practice quality of physicians. These evaluations must be conducted on a regular basis and measure a practitioner’s clinical and behavioral competence in six areas: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.\textsuperscript{51}

Maintenance of certification (MOC) programs sponsored by the American Board of Medical Specialties (ABMS) and its 24 member boards promote CPD. The Member Boards require most medical specialists to seek recertification on a periodic basis, typically every 10 years, by successfully completing assessments designed to test medical knowledge, clinical competence and skills in communicating with patients. MOC’s impact is limited, however, in that many older physicians are “grandfathered” or have time-unlimited board certifications. Furthermore, the process does not address those physicians who are not board certified.\textsuperscript{67,69} Choudhry suggests that older physicians may need the quality interventions that are appropriate for all physicians and raises concerns that much of existing CME may not help them maintain their quality of care.\textsuperscript{18} Many older physicians are exempt from MOC requirements that might provide a venue for helping to maintain their competence.\textsuperscript{18}

When competency to practice safely is in question, the approach is individualized because there is a continuum of competency. If the physician is an immediate threat to the public welfare, or has an irreversible cognitive impairment or an untreated condition, the state medical board can revoke the medical license. If the condition is potentially reversible, state medical boards and hospitals may refer physicians to specialized programs for competency to practice assessments and remediation. These programs evaluate a physician’s clinical knowledge, reasoning, judgment, documentation and patient care as well as neuropsychological status. Organizations such as the Coalition for Physician Enhancement have a mission to support, develop and certify those with expertise in assessment and education enhancement for physicians and other health-care providers. There are approximately 10 remediation programs in the United States.\textsuperscript{5}
RETRAINING MAY BE NEEDED TO ALLOW PHYSICIANS TO CONTINUE TO PRACTICE

It is the opinion of the Council on Medical Education that remediation should be a supportive, ongoing and proactive process and that physicians should be allowed to remain in practice as long as patient safety is not endangered. Remediation programs offer many educational approaches including formal CME. Traditional CME courses developed for the average physician are often used as a resource for physicians needing remediation. Lobprabhu, et al. suggest that the remediation program should include remedial CME for the identified area of dyscompetence, as well as pre- and post-testing to determine whether the physician learned the material presented. The type of testing and the criteria for successful remediation may differ according to specialty.

Norman comments that “physicians undergoing remedial education are at high risk for failure and conventional education may be unsuccessful.” In particular, cognitive dysfunction may negatively impact a physician’s ability to remediate successfully. Thus, assessment of neuropsychological function may be of value in supporting decisions about the potential utility (vs. futility) of further remediation and assessment, particularly if cognitive problems are identified in older physicians with significant competence deficits. Kohatsu commented that their research findings had potential policy implications for use of board certification in credentialing, and they support the efforts of the ABMS to enhance the development and assessment of physician life-long learning and continuing competence.

Barriers associated with remediation programs include the high cost of programs; the dispersed location of programs; the lack of a comprehensive database to inform physicians about assessment and remediation programs, such as structure, requirements, costs and outcomes; the lack of standardized curricula; and the lack of a sufficient monitoring process to assess program outcomes. Further, due to the relatively small number of assessment programs that address cognitive and other impairments, physicians are unlikely to be assessed within the context of their own practice.

APPROPRIATENESS OF GUIDELINES FOR TESTING FOR AND JUDGMENT OF A PHYSICIAN’S COMPETENCE TO CARE FOR PATIENTS

Deciding when to give up practice is an important decision for any physician, and it is critically difficult for some. Normal aging is associated with cognitive changes; some are positive (e.g., accumulated wisdom), but most are usually associated with some decline. However, increased intelligence and greater educational achievement appear to be protective to some extent. Nonetheless, physicians, similar to non-physicians, are at risk of mild cognitive impairment and dementia, and physicians with either condition, often lack insight into their deficiencies. These physicians may be resistant to suggestions that it is time to retire from practice.

Many wise physicians have asked trusted younger colleagues to tell them when it is time to stop. 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. Clinical performance measurement and patient safety event reporting are used now for medical staff assessment of professional competency.

In years past, local medical societies would perform this function for their members. More recently, medical staffs and department chiefs have dealt with the issue on an ad hoc basis, and with medical staff peer review processes on a more formal basis. With the recent shift away from hospital practice and the current competitive and litigious environment, formal guidelines on the timing and content of testing of competence may be appropriate. How often this testing should occur is not
well defined. Unfortunate outcomes may trigger an evaluation at any age, but perhaps periodic
reevaluation after a certain age such as 70, when incidence of declines is known to increase, may
be appropriate. This testing should include evaluation of physical and mental health,
neurocognitive testing, and review of actual clinical care, either by direct observation or chart
review. Physicians must generate and agree on the appropriate guidelines themselves. Following
formal guidelines may head off a call for mandatory retirement ages, as pilots experience, or
imposition of guidelines by others.1

SUPPORT FOR AGING PHYSICIANS

Some physicians are glad to move into a different phase of their lives when they reach age 70. For
others, however, this transition is not easy, and it may require the guidance and support of peers.
For this reason, it is important for medical staff leaders to understand how to support and respect
long serving colleagues. Physicians with decades of experience and contribution deserve the same
sensitivity and respect afforded their patients as they experience health changes that may or may
not allow continued clinical practice.72

Shifting away from procedural work, allocating more time with individual patients, using memory
aids and seeking input from professional colleagues might help physicians successfully adjust to
the cognitive changes that accompany aging.5,58 Eva suggests that findings from the literature may
also identify ways that to alter the practice environment or tailor approaches to CPD to help
mitigate the effects of age-associated cognitive changes.9,10 These findings include:

- Increased environment supports, such as simplified documentation forms for recording data
  and thus decreasing the need for working memory, freeing cognitive resources for other
  activities;
- Decreased case load/decreased time demands;
- Narrowing or limiting scope of practice;
- Enhancing the clarity of various stimuli provided to older physicians, such as increasing the
  contrast and resolution of radiographic images; and
- Focus on analytic components of medical diagnosis in CPD.

The AMA also provides support for aging physicians through a special membership section that is
the largest such group in the United States. The AMA Senior Physicians Section (SPS), which
comprises all AMA member physicians age 65 and older, sponsors educational activities on topics
of interest to the senior physician community. Recent programs included:

- “The Aging Physician: Opportunities and Challenges,” held in June 2013, focused on
  understanding impairment in older physicians as well as facilitating the planning of prevention
  strategies. The session examined what role the AMA should play in determining competency
  measurements in an aging workforce. (www.ama-assn.org/ama/pub/about-ama/our-
  people/member-groups-sections/senior-physicians-section/education-programs.page)
- “Grow Healthier as You Grow Older,” held in June 2014, focused on the challenges and
  opportunities physicians face in maintaining health and well-being and provided insights into
  how to improve health outcomes in the senior population. (www.ama-assn.org/ama/pub/about-
  ama/our-people/member-groups-sections/senior-physicians-section/meetings.page?)
AMA POLICIES

The AMA has policy in which it urges members of the profession to discover and rehabilitate if possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions that impair a physician’s current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are attached (see Appendix).

SUMMARY AND RECOMMENDATIONS

Regulators and policymakers are considering some form of age-based competency screening due to the increasing number of older physicians, the call for increased accountability by the public and concerns for patient safety. Although some studies among physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician’s competence can be highly variable. Furthermore, assessment of competence among aging physicians poses unique challenges related to the uncertain and variable influence of aging on clinical competence and performance in practice.

It is part of a physician’s professional duty to continually assess his or her own physical and mental health, as well as to report all instances of significantly impaired or incompetent colleagues to hospital, clinic or other relevant authorities. However, this method is not always reliable. Contemporary methods of self-regulation (e.g., clinical performance measurement; CPD requirements, including novel performance improvement CME programs; and new and evolving MOC programs) have been created by the profession to meet shared obligations for quality assurance and patient safety. Some hospitals and medical systems have initiated age-based screening, but there is no national standard, and older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

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.

It should be noted that the development of guidelines/standards for appropriate mechanisms to assess aging/late career physicians will require significant resources to convene meetings (live and virtual) of experts and stakeholders—especially in view of the limited and conflicting data available on this topic. Furthermore, if a uniform set of guidelines was to be identified, it would have to be consistent with state regulations at a number of levels.

The Council on Medical Education recommends that the following recommendations be adopted, and that the remainder of the report be filed.
1. That our American Medical Association (AMA) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that aging/late career physicians remain able to provide safe and effective care for patients. (Directive to Take Action)

2. That our AMA encourage organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the aging/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (Directive to Take Action)

3. That our AMA rescind Policy D-275.959, Competency and the Aging Physician, since this directive has been accomplished through this report. (Rescind HOD Policy)

Fiscal Note: $5,000
APPENDIX – AMA POLICIES

D-275.959, Competency and the Aging Physician
Our AMA will study the issue of competency in aging physicians and develop guidelines, if the study supports such a need, for appropriate mechanisms of assessment to assure that America’s physicians remain able to provide optimal care for their patients and report back to the House of Delegates. (Res. 308, A-14)

H-275.998, Physician Competence
Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRDP Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, Medical Licensure
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician’s current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician’s knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges
licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12; Appended: Res. 305, A-13)

H-300.973, Promoting Quality Assurance, Peer Review, and Continuing Medical Education
Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA’s Physicians’ Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

H-275.996, Physician Competence
Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

D-295.325, Remediation Programs for Physicians
1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level.
2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care.
3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians.
4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.

5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians. (CME Rep. 3, A-09)

H-275.936, Mechanisms to Measure Physician Competency

Our AMA (1) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (2) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12)
REFERENCES

ASSESSING LATE CAREER PRACTITIONERS:
Policies and Procedures for Age-based Screening

A Guideline from
California Public Protection and Physician Health, Inc.

CONTENTS

I. INTRODUCTION .................................................................................................................. 3
   A. STATEMENT OF PURPOSE .......................................................................................... 3
   B. THE EVIDENCE ON WHICH THIS DOCUMENT IS BASED ..................................... 4
   C. THE AUTHORS ............................................................................................................. 4
   D. DISCLAIMER ................................................................................................................. 4

II. THE CLINICAL CASE FOR ASSESSING LATE-CAREER PRACTITIONERS ...................... 5

III. CRAFTING A POLICY: ELEMENTS OF AN EFFECTIVE POLICY .................................... 6

IV. ADOPTING THE POLICY .................................................................................................. 8

V. IMPLEMENTING THE POLICY .......................................................................................... 8
   A. ADMINISTERING THE SCREENING ASSESSMENT .................................................. 8
      1. History and physical examination ........................................................................... 8
      2. Peer assessments ...................................................................................................... 9
      3. Observations from others in the clinical setting .................................................... 9
      4. Assessment of cognitive function ......................................................................... 9
   B. IDENTIFYING QUALIFIED EVALUATORS ............................................................... 9
   C. SCHEDULING THE ENTIRE ASSESSMENT PROCESS .............................................. 10
   D. PROVIDING INFORMATION TO THE EVALUATOR(S) IN ADVANCE ........................... 10
   E. WHAT IS REQUIRED IN REPORTS FROM THE EVALUATORS TO THE WELLBEING COMMITTEE? ................................................................. 11
   F. THE WELLBEING COMMITTEE’S RESPONSE ......................................................... 11
   G. REPORTS FROM THE WELLBEING COMMITTEE TO THE CREDENTIALS COMMITTEE ................................. 12
   H. MEDICAL STAFF’S RESPONSE TO REPORTED CONCERNS OF AGE-RELATED IMPAIRMENTS ..................... 13

VI. INFRASTRUCTURE REQUIRED TO IMPLEMENT THE POLICY ....................................... 13

VII. LEGAL CONSIDERATIONS ON WHICH POLICIES ARE BASED .................................. 13
   A. AGE DISCRIMINATION .............................................................................................. 14
   B. DISABILITY DISCRIMINATION .................................................................................. 14
   C. REASONABLE ACCOMMODATION .......................................................................... 15
   D. DEFENDING AGAINST A LEGAL CHALLENGE ....................................................... 16

VIII. RESTATEMENT OF PURPOSE ...................................................................................... 16

IX. GUIDELINES AND DOCUMENTS CITED ........................................................................... 16

X. APPENDICES ..................................................................................................................... 18
A. APPENDIX A: REGARDING THE EVIDENCE OF VALIDITY, PREDICTABILITY, RELIABILITY OF SCREENING INSTRUMENTS...............................................................18
B. APPENDIX B: SAMPLE FORMS........................................................................................................19
   1. Form requesting and reporting a medical assessment..............................................................19
   2. Form requesting and reporting a neuropsychological assessment........................................21
   3. Form reporting a peer assessment...........................................................................................23
   4. Form reporting observations from nursing staff or others in the clinical setting..................25
C. APPENDIX C: MODEL MEDICAL STAFF BYLAWS......................................................................26
D. APPENDIX D: WELLBEING COMMITTEES....................................................................................29
E. APPENDIX E: FREQUENTLY ASKED QUESTIONS.....................................................................30
   1. Do HIPAA protections apply to the reports of the screening or the full evaluations?.........30
   2. What is the relationship between age-based screening and a fitness for duty evaluation?30
   3. What must be reported to the Medical Board of California and the National Practitioners
      Data Bank? ............................................................................................................................31
F. APPENDIX F: REFERENCES...........................................................................................................33
G. APPENDIX G: LEGAL ASPECTS OF AGE-BASED SCREENING ...................................................34
   1. The Evolution of Age Discrimination Laws............................................................................34
      a) Legislation..........................................................................................................................34
      b) The Treatment of Age Discrimination in the Courts.........................................................35
   2. Elements of a Physician Claim of Age Discrimination.........................................................36
      a) The Employee vs. Independent Contractor Element.........................................................36
      b) The Bona Fide Occupational Qualified Qualification (“BFOQ”) Defense............................37
   3. Disability Discrimination Laws.............................................................................................37
      a) Screening Exams ...............................................................................................................38
      b) Reasonable Accommodation............................................................................................39
   4. Defending Against a Legal Challenge....................................................................................39
I. **INTRODUCTION**

The implications of greater human longevity and rapidly increasing work-life expectancy are complex and the subject of intense study, particularly as they relate to the delivery of health care. Ensuring that the U. S. health care system will have the workforce capacity needed to deliver care to the increasing numbers of patients that have been projected has been identified as a priority.

On the one hand, studies show that greater levels of experience in medicine, as in other industries, result in higher quality care. We ascribe benefit to the greater experience accumulated with more years of practice being brought to bear on patient-care decisions by physicians and other health care workers.

On the other hand, studies also demonstrate that the effects of aging directly impact the specific physiological and cognitive functions relied upon by physicians in carrying out their job-related responsibilities. In fact, studies have found a direct correlation between decline in these areas of function and adverse outcomes for patients. The studies cited in the appendix necessitate an examination of how to evaluate and address any decline in levels of function that might impact patient care and a consideration of whether using age as a factor in our evaluation mechanisms is an effective way of protecting patients.

The legal framework surrounding this issue is responsible for additional complicating forces. Both Federal and State law mandate that entities that employ, contract with or grant privileges to physicians to provide services to patients—including hospitals, medical staffs, and physician groups—engage in active oversight of the quality of care rendered by physicians practicing at their facilities. Case law clearly establishes that hospitals and physician groups can be held directly liable for injuries caused to patients by physicians where there was evidence of deficiencies in the physician’s skills or judgment that posed a danger to patients.

The law does not, however, allow unfettered discretion to entities charged with the responsibility of quality oversight. The law has created an expansive view of the property right of members of medical staffs to practice their trade free from arbitrary actions by hospitals, medical staffs and others. This includes a physician’s right to be free from discrimination based on race, color, gender, sexual orientation, national origin, age and disability. Thus is created the dynamic tension between the need to protect the public and the patient and the need to protect the individual healthcare provider.

A. **STATEMENT OF PURPOSE**

This document is intended to assist all those in medical staffs, medical groups, and other entities that have responsibility for decisions related to evaluating a practitioner’s health and wellbeing as they impact the practitioner’s ability to practice medicine safely. (Hereinafter, the document uses “medical staff” to refer to all the entities with this responsibility.) The document describes guidelines and principles and provides information specific and detailed enough to form the basis for decisions to be made by each entity. It does not replace the judgment of the decision makers applied to individual circumstances.
This paper will also review the evolution and impact of age and disability discrimination laws on the options available for evaluating physician competency. As will be seen, age and disability discrimination laws have unique aspects that in many ways grant flexibility to institutions in shaping policies and actions designed to address quality and protect patients. These laws are complex and care must be exercised in creating and implementing policies so as to maintain the values that underlie the extensive network of laws that prohibit discrimination. This paper will examine the intersections of the multiple competing forces in the discussion of the available options for assessing physicians who choose to work late into their careers.

Most importantly, this paper will posit that this issue can be properly addressed only if it is addressed by all stakeholders as a shared responsibility: by practitioners who, ideally, should assess their own level of skill and any changes which might impact their ability to deliver quality care and by institutions responsible for maintaining quality care and protection of the patients. To be effective and successful, policies and procedures must balance the interests of all involved in assuring safety of patient care.

A necessary starting point is an examination of the studies that identify and quantify the impact of age on quality, and the implications of the data for entities charged with ensuring quality.

**B. THE EVIDENCE ON WHICH THIS DOCUMENT IS BASED**

The guidelines in this document are designated by the author as Level C, "the consensus of expert opinion," under the American Academy of Family Physicians' rating system for levels of evidence used, as described in its journal, *American Family Physician*.

**C. THE AUTHORS**

This document was prepared by a workgroup comprised on persons who are members of the California Medical Association, the California Hospital Association’s Center for Healthcare Medical Executives, and California Public Protection and Physician Health, and attorneys from Procopio, Cory, Hargreaves & Savitch LLP (the "Workgroup").

Review and comments were requested from other interested stakeholders, including nationally recognized experts in the evaluation of health care professionals. All comments received were considered, and corresponding changes approved by the Workgroup were incorporated into this document.

The document was adopted by the CPPPH Board on April 14, 2015. It will be subject to periodic review and revision to incorporate new developments. If the document is revised, it will be circulated for comment again and published with a new date.

**D. DISCLAIMER**

The guidelines set forth in this document are general in nature, do not constitute legal advice and should not be used as the sole basis for decision- or policy-making or as a substitute for obtaining competent legal counsel.

The guidelines contained herein are not entirely inclusive, exclusive or exhaustive of all reasonable methods or approaches to age-based screening. This document does not advocate
in favor of or against mandatory or permissive age-based screening nor is it intended to replace the judgment of decision-makers applied to individual circumstances. While these guidelines take into account variations in practice settings, resources, and common physician skills and characteristics, they cannot address the unique circumstances of each situation.

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II. The Clinical Case for Assessing Late-Career Practitioners

According to the American Medical Association (AMA), in 2012, 42% of the nation’s one million physicians were older than 55 and 21% were older than 65.¹ This is compared with 35% and 18% respectively in 2006.² The rising number of physicians practicing later in life raises concerns about the potential impact aging physicians have on patient safety. This is particularly troubling given the various studies finding that when people reach their 60s and 70s, there is often a significant and progressive decline in cognitive and physical skills. This is true of physicians as well. For example, a 1994 Harvard study found that “overall, physicians scored higher in cognitive functioning from ages 25-55, but thereafter there was a consistent and more precipitous decline with increasing age in the areas of cognitive function (as measured by the MicroCog™ assessment tool), inductive reasoning, verbal memory, and overall reasoning.”³

A 2006 report found that patient mortality rates in some complex operations were higher when the surgeons were older than 60 than for their younger colleagues.⁴

A retrospective review of 148 doctors with performance problems demonstrated relative deficits on tests in sequencing, attention, logical analysis, eye-hand coordination, and both verbal and

² Id.
non-verbal learning. The study concluded these deficits were sufficient to explain the performance difficulties.

Published studies provide evidence that as physicians age, they experience a higher likelihood of physical and cognitive limitations or impairment than their younger colleagues, which can have a potentially negative impact on patient care and safety. This is not to say that all physicians over a certain age pose a safety risk, as many continue to function without difficulty (without significant decrease of either cognitive or physical skill and performance) into their 70s and 80s. Determining which individuals may pose a safety risk is the duty of those in the hospital or other medical setting who are responsible for protection of patients and quality of care delivered. Because many of the diseases and processes that are more likely to occur with increasing age happen insidiously and with few or no symptoms recognized by the physician nor signs apparent to those around him/her, screening assessments are one way to provide the first information on which those determinations can be made. Screening is used to indicate whether a physician’s abilities match his or her practice requirements or whether further testing and evaluation are needed before that judgment can be reached.

III. CRAFTING A POLICY: ELEMENTS OF AN EFFECTIVE POLICY

The policy that authorizes age-based screening should articulate and document the purpose, the rationale, and the authority for requiring the assessment. Those who may be called upon to defend an institution’s practices against a legal challenge will look first to the policy. The policy should address key issues clearly and directly in a way that guides and governs the steps used to implement it. The policy should:

1) specify that the requirement for assessment applies equally to all members of the medical staff who have reached the specified age

2) state that the requirement for evaluation is based solely on the age of the practitioner.

Note that this policy is unrelated to an assessment made “for cause” or in response to an indication of compromised performance. Assessments for cause are addressed in other documents: California Medical Association OnCall Document #5177 Guidelines for Hospital Medical Staff Wellbeing Committees Policies and Procedures [September 2013] and Evaluations of Healthcare Professionals [CPPPH 2013]

3) specify the age at which the first screening is required

The decision about the age at which a policy takes effect has important implications for a potential legal challenge to the policy. In order to defend a policy on patient-safety grounds, the age at which the policy goes into effect should have a direct connection to the age at which there is an increased risk of age-related impairments as documented in the literature. Institutions should closely monitor the research related to age-related impairments and regularly reassess their policies to ensure that


6 Id.
the age designated in the policy is accurately aligned with the current literature on the subject.

4) specify that the requirement is made a part of the reappointment and privileging process

5) establish the frequency with which reassessments are required for reappointment

6) establish who pays each of the costs of the assessment

   There is no one recommended way to handle costs. Appropriate choices include payment being the responsibility of the person being assessed, the responsibility of the medical staff or medical group, or a shared responsibility. See Guidelines for Evaluation of Healthcare Professionals [CPPPH 2013]

7) establish the requirement that the practitioner provide a release allowing evaluators’ reports to be given to the medical staff Wellbeing Committee, regardless of who paid for the assessment(s)

8) establish what information is protected and kept confidential within the Wellbeing Committee and under what authority it is protected

   The policy should specify that all information related to the screening process is kept confidential, what records are generated, how the information will be protected.

9) specify the roles, responsibilities and charges to each committee or officer of the medical staff or medical group in implementing the policy

   Because of its charge to advise and assist the members of the medical staff and to maintain confidentiality of the information except when the safety of a patient is threatened, the Wellbeing Committee is the most appropriate committee to be responsible for implementation of the policy up to the delivery of its recommendation to the practitioner and to the Credentials Committee. The policy should establish that the function of the Wellbeing Committee in coordinating this process includes the duty to support the practitioner. This charge should be added to the bylaws section that specifies the duties of the Wellbeing Committee.

10) establish that the Wellbeing Committee has no authority to take disciplinary action or any action related to privileging, but will report its findings to the Credentials Committee

11) establish that the Wellbeing Committee has the authority to set criteria for identifying qualified evaluators, to require qualified evaluators, and to approve the choice of the evaluator(s) for each practitioner. For qualifications of those who conduct evaluations, see Guidelines for Evaluation of Healthcare Professionals [CPPPH 2013].

12) authorize the Wellbeing Committee to recommend additional evaluation after reviewing the reports of screening assessments

13) establish that the charge to the Wellbeing Committee is to evaluate the information received and to advise the practitioner and the Credentials Committee

14) specify the consequences to the practitioner of failure to comply with all the requests during the assessment process or failure to complete the assessment process, i.e., such failure will result in an incomplete application and lapse of privileges
IV. Adopting the Policy

Crafting a policy is only the first step. Involving and informing all members of the medical community and allowing sufficient time for review, questions and discussion, are considered necessary for a smooth and successful adoption of the policy. It is helpful to circulate information about the policy in advance and provide the supporting research on which it is based, showing the correlation between age and adverse patient outcomes.

It is critical that all members of the medical staff or medical group understand that the policy is aimed at both protecting patient safety and safeguarding the career of the practitioner, and that it incorporates protections against discrimination of any sort.

Special outreach to those impacted by the policy, and those soon to be impacted, may be in order. For example, the medical staff leadership might personally contact every practitioner affected by the policy during the period that the draft is being developed to engage them in a review of the principles involved and to address any questions or concerns they may have.

After the policy is adopted and implemented, it is helpful to reiterate, on a regular schedule, the principles on which the policy is based and how they address the interests of all involved. An annual educational activity designed for the entire medical staff is helpful in maintaining support for the policy.

V. Implementing the Policy

The Wellbeing Committee should begin by defining the procedures it will follow and making them known to the members of the medical staff. The procedures should guide the actions of the Wellbeing Committee so that each case is handled similarly and in accordance with the procedures. The procedures should address each of the following elements.

A. Administering the Screening Assessment

A screening assessment is a combination of elements and reports considered together. The Wellbeing Committee should identify the elements to be included and the experts who will identify the screening instruments to be used. The four core elements – physical examination, assessments from peers and co-workers, and assessment of cognitive function – are discussed below.

In order to defend a policy against a legal challenge, it is important that the screening (and any further assessments) required accurately assesses a physician’s capacity to perform the privileges currently held or requested at the time of reappointment.

1. History and Physical Examination

There should be a general history and physical examination including a screening for depression/other mental health or emotional issues, a screening for alcohol/substance abuse/addiction, and tests of both hearing and vision.
2. **PEER ASSESSMENTS**

There should be a review of the practitioner’s current performance conducted by a peer. Those who conduct such peer assessments may be nominated by the practitioner but must be approved by the Wellbeing Committee. (The Wellbeing Committee should have presented a list of pre-approved assessors. It is recognized that peer assessments may be influenced by personal relationships that must be taken into account when the Wellbeing Committee approves the person to make the peer assessment.

The person making and reporting the peer assessment should include observations of each of the ACGME Core Competency areas: Professionalism, Interpersonal and Communication Skill, Medical Knowledge, Practice-based Learning and Improvement Patient Care, and Systems-based Practice. An example of a peer assessment form is in Appendix B.

3. **OBSERVATIONS FROM OTHERS IN THE CLINICAL SETTING**

Because a change in behavior may be an early sign of decline in professional performance and because such a change may be noticed first by personnel in the clinical setting, it is important to include observations and information from persons in the work setting. Examples are observation from operating room supervisors for all surgeons, floor managers for non-surgical specialists, and risk management staff for all practitioners. Examples of such reports are in Appendix B.

4. **ASSESSMENT OF COGNITIVE FUNCTION**

An assessment of cognitive function is an essential element in determining the physician’s ability to perform his/her current or requested privileges safely. Screening instruments such as, for example, the MicroCog™, St. Louis University Mental Status (SLUMS) Examination, or Montreal Cognitive Assessment have been studied and their effectiveness reported. In Appendix A there are notes regarding the validity, predictability and reliability of the instruments that assess cognitive function.

If a recognized screening instrument that tests cognitive function is not to be used, alternative methods should be employed to gather information on which judgments can be made about the practitioner’s cognitive abilities. For example, the medical staff could design a combination such as physical examinations repeated at a specific intervals, plus regular peer evaluations from two physicians familiar with the practitioner’s work, on a frequency to be determined, and observations by others in the clinical setting.

B. **IDENTIFYING QUALIFIED EVALUATORS**

The Wellbeing Committee should identify those qualified to conduct and report the screening assessment of cognitive function. See *Evaluations of Healthcare Professionals* (CPPPH 2013)

The Wellbeing Committee should provide a list of two or more qualified evaluators for each element of the assessment process from which the evaluee may choose.
Qualifications of those who conduct and report the results of screening assessments are different from the qualifications required of those who conduct additional testing. Qualifications appropriate for those chosen to conduct the screening include these elements:

- Experience: at least three years’ experience in practice in his/her respective specialty
- Previous experience assessing physicians is desirable
- For neuropsychological screening assessment, evidence of specialty training in cognitive and neurological disorders and testing
- For screening for substance use disorders, demonstrated knowledge and understanding of addiction, treatment and recovery
- No conflict of interest or duality of interest with evaluatee or referring entity
- Licensure: licensed health care professional with current unrestricted license with no disciplinary history within the previous five years
- Demonstrated ability to provide reports on time, with sufficient and appropriate information to support peer review action

Qualifications appropriate for those chosen to conduct additional testing and evaluation are discussed in Guidelines for Evaluations Of Health Care Professionals [CPPPH 2013] and include these additional elements:

- Specialty or subspecialty certification or equivalency
- Previous experience assessing physicians is desirable
- Demonstrated ability to provide reports that describe the nature of any decrements in performance and describe how such decrements or vulnerabilities might affect the ability to perform the tasks required for the evaluatee’s practice and privileges

C. SCHEDULING THE ENTIRE ASSESSMENT PROCESS

The Wellbeing Committee should coordinate the schedule for the assessment process with the evaluatee and all those providing reports. The scheduling of evaluations must allow for sufficient time for each step to be completed. The Committee should remind the evaluatee of the policy that specifies that failure of the practitioner to make or keep the scheduled appointments for assessments is considered failure to comply with the process.

D. PROVIDING INFORMATION TO THE EVALUATOR(S) IN ADVANCE

For the screening assessment, the evaluator must know the practitioner’s specialty and what privileges are being requested. For additional testing, additional information must be provided to the evaluator. See Evaluations of Healthcare Professionals (CPPPH 2013)
E. WHAT IS REQUIRED IN REPORTS FROM THE EVALUATORS TO THE WELLBEING COMMITTEE?

The reports to the Wellbeing Committee should include the evaluator’s conclusion stating whether there are or are not findings that may potentially affect the practitioner’s professional performance and whether additional testing is needed.

If additional testing is conducted, the reports of the additional evaluation that may include testing should describe the nature of any decrements in performance found and describe how such decrements or vulnerabilities might affect the ability to perform the tasks required for the physician’s practice and requested privileges.

Appendix C provides a sample report with a discussion of how it is interpreted in relation to privileging.

F. THE WELLBEING COMMITTEE’S RESPONSE

After reviewing the reports of the screening assessments, the Wellbeing Committee should decide whether to require additional testing in order to make its decision and report to the Credentials Committee.

If the reports from the screening process identify questions that raise concerns about a physician’s ability to perform the requested privileges safely, the Wellbeing Committee should review the results with the physician, identify what further evaluation(s) are needed, and provide a list of at least two qualified evaluators. If additional testing and further evaluation are needed, the Wellbeing Committee should coordinate them and help the practitioner schedule them.

Reports of the additional evaluation(s) may indicate vulnerabilities significant enough to warrant ongoing watchfulness for further diminution of skills and abilities, but not sufficient to warrant reduction of privileges at that time. If so, the Wellbeing Committee should design a monitoring process appropriate to the situation and offer to monitor the practitioner on an ongoing schedule appropriate to the situation. In the interactive process with the practitioner, the Wellbeing Committee can offer such an option with the understanding that the practitioner must sign an agreement with the Wellbeing Committee for the continuing interaction with the Wellbeing Committee for the purpose of being so monitored. The implementation of all steps to carry out such a monitoring agreement should be handled according to the medical staff’s policies and procedures for the Wellbeing Committee.

If the practitioner signs such an agreement, the report to the Credentials Committee would be that the practitioner had completed the assessment process. As long as the practitioner cooperates with all elements of the monitoring plan and schedule, and as long as his/her skills and abilities remain sufficient to support safe patient care, no report would be made to the Credentials Committee or MEC.

If the reports indicate an impairment or diminution of skills and abilities sufficient to warrant a modification of privileges, an interactive process between the practitioner and the Wellbeing
Committee should be conducted with the goal of helping the practitioner modify his/her privileging request in order to practice competently. For example, institutions can create co-management privileges to transition the practitioner from independent privileges to refer-and-follow privileges. (Refer-and-follow privileges may be defined differently by different institutions, but they can be ambulatory privileges that allow physicians to refer patients to the hospital, order ancillary studies from an outpatient setting, and follow their patients in the hospital.) The Wellbeing Committee can encourage the physician to transition to a part-time hospital practice or reduce the call schedule or to make the decision to retire.

While the Wellbeing Committee’s role and function during this process would follow the institution’s bylaws, policies and procedures, the Committee’s actions should be supportive and respectful and should include recommending approaches for the practitioner to respond to any concerns.

Since the Wellbeing Committee is not a credentialing or disciplinary body, these discussions would not constitute an investigation. Following the discussions, if the practitioner initiates a request for a change to his/her privileges, no reporting to the Medical Board would be required. (See question #3 in Appendix F.) All information resulting from the assessments should remain confidential as products of the Wellbeing Committee, following the policy that establishes what information is protected and kept confidential and under what authority it is protected.

In the event that the report(s) raises concerns that the health of the medical staff member poses an unreasonable risk of harm to patients, and if the medical staff member does not initiate a change in his/her practice and privileges as recommended by the Wellbeing Committee or comply with a monitoring agreement designed by the Wellbeing Committee, that information should be forwarded to the Credentials Committee or the Medical Executive Committee in accordance with the organization’s bylaws and/or policies. The Credentials Committee and the Medical Executive Committee (MEC) are responsible for deliberation, determining what action to take, and taking action.

G. REPORTS FROM THE WELLBEING COMMITTEE TO THE CREDENTIALS COMMITTEE

When the Wellbeing Committee determines that it has reached the end of the interactive process with the practitioner and when the Wellbeing Committee has agreed upon its recommendations, the report should be forwarded to the Credentials Committee or the Medical Executive Committee in accordance with the organization’s bylaws and/or policies. The report should be one of the following:

- the statement that the practitioner has completed the Committee’s assessment process.
- the statement that the practitioner failed to complete the Committee’s assessment process and/or failed to complete the subsequent steps in the Committee’s process.

The information on which the Wellbeing Committee’s report to the Credentials Committee is based should remain confidential with the Wellbeing Committee.
H. **MEDICAL STAFF’S RESPONSE TO REPORTED CONCERNS OF AGE-RELATED IMPAIRMENTS**

Consistent with the Americans with Disabilities Act (ADA) and/or the Rehabilitation Act, the medical staff must engage in an interactive process with the practitioner and, if possible, make reasonable accommodations to enable him or her to continue to practice safely in light of the concerns named in the reports of the further evaluations performed. Properly doing so could avoid claims for violation of the ADA.

If the concerns are such that they cannot be alleviated by a reasonable accommodation, and if the concerns represent foreseeable and significant threats to patient safety, it would not violate the ADA to require a significant reduction in clinical privileges.

In some situations, but not all, changes or limitations on privileges made by the MEC require a report to the Medical Board of California and the National Practitioners Data Bank. See Appendix F.3: What must be reported?

VI. **INFRASTRUCTURE REQUIRED TO IMPLEMENT THE POLICY**

For an effective implementation of the different steps of this policy, the medical staff should have in place several elements:

- medical staff services department with sufficient staff support for the Credentialing Committee and the Wellbeing Committee and sufficient time to take on the necessary elements of reappointment process
- wellbeing committee with enough active members who have the appropriate experience and expertise
- capacity to maintain confidential records
- sufficient funding to pay for assessments (if the policy says that the medical staff pays)
- access to a sufficient number of qualified evaluators who can meet the medical staff’s need for reports with sufficient information within a certain time frame

Medical staffs without the resources listed above may contract with other entities to perform some or all of the steps involved.

VII. **LEGAL CONSIDERATIONS ON WHICH POLICIES ARE BASED**

Generally speaking, an employer or medical staff can, and must, take a physician’s health into account in both the hiring and privileging processes. See *Joint Commission Comprehensive Accreditation Manual for Hospitals, MS.06.01.05(6)*. The American Medical Association’s *Code of Medical Ethics* requires physicians to both maintain their health and wellness and, when an issue arises, “take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing.” *AMA Code of Medical Ethics Opinion 9.0305- Physician Health and Wellness. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion90305.page#*
Physicians are ethically obligated to report impaired colleagues when they believe the impairment interferes with the colleague’s ability to engage safely in professional activities. 


Age-based medical screening exams implicate federal and state laws, which prohibit discrimination based on age and disabilities. These laws are complex and contain many exceptions and variables, which must be factored into any discussion of age-based screening and actions based on the findings of any screening process. The history and development of these laws are set forth in detail in Appendix F.

A. **Age Discrimination**

The federal Age Discrimination in Employment Act (ADEA) and state age discrimination statutes prohibit the arbitrary use of age in decisions that impact the employment status of individuals. These laws apply to practitioners and there are many cases in which physicians have alleged age and other forms of discrimination in challenges to hospital medical staff decisions to impose corrective action. None of the reported cases involve a physician challenge to an age-based screening policy.

While the federal and state laws prohibiting age discrimination declare that age shall not be used to adversely affect any individual, the laws are most noteworthy for their exceptions. Unlike race, religion, nationality and other immutable characteristics, physical and cognitive decline associated with age have been recognized by Congress, state legislatures and courts as posing risks in the workplace, both to the employee and others. This is particularly true when public safety is at issue. Thus, mandatory retirement policies and screening based on age have been imposed through legislation, (e.g., for airline pilots and law enforcement), and by industries responsible for public safety, (e.g., for bus drivers). As set forth in the analysis in Appendix G, the healthcare industry, strangely, has been omitted from legislation allowing for age-based measures to monitor and ensure patient safety. This has created a great deal of uncertainty for hospitals, medical staffs and physicians considering screening policies.

B. **Disability Discrimination**

The federal Rehabilitation Act of 1973 and Americans with Disabilities Act (ADA), as well as state disability discrimination laws, prohibit adverse employment actions based on an individual’s disability. Like age discrimination, however, the laws implicitly recognize the right of employers, including hospitals and their medical staffs, to consider a disability in determining whether an individual can safely perform his or her job duties.

Disability discrimination laws do not expressly preclude disability-related inquiries or medical screening examinations. Rather they place certain limits on the stage at which health-related inquiries can be made and on the scope of any inquiry. According to the EEOC, “[t]he ADA’s provisions concerning disability-related inquiries and medical examinations reflect Congress’s intent to protect the rights of applicants and employees to be assessed on merit alone, while
Assessing Late-Career Practitioners: Policies and Procedures for Age-based Screening
A Guideline from California Public Protection & Physician Health / 2015

protecting the rights of employers to ensure that individuals in the workplace can effectively perform the essential functions of the job.” See EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000).

An employer may make disability-related inquiries and require a medical examination only if they are “job related and consistent with business necessity.” A disability-related inquiry or medical examination of an employee is “job-related and consistent with business necessity” when an employer “has a reasonable belief, based on objective evidence, that: (1) an employee’s ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition.” Periodic medical examinations and other monitoring under specific circumstances may be job-related and consistent with business necessity.

Employers may also require periodic examinations of employees in positions affecting public safety such as police officers and firefighters. Where examinations are required by safety regulations, an employee cannot assert an ADA claim as barrier to employer compliance with regulations.

Equally important are court cases that have held that physicians and other providers may not seek protection of disability discrimination laws where the provider poses a direct threat to the health and safety of other individuals in the workplace. 42 U.S.C.§ 12113(b); 42 U.S.C.§ 12182(b)(3). The term “direct threat” is defined in this section to mean “a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.” 42 U.S.C.§ 12111(3).

The determination of whether an employee poses a direct threat must be based on “an individualized assessment of the individual’s present ability to safely perform the essential functions of the job,” which itself must be based on “a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence.” 29 C.F.R. § 1630.2(r). This assessment should consider four factors: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. Id.

C. Reasonable Accommodation

The final question here relates to the actions which are available should a screening examination reveal some form of process causing or potentially contributing to an impairment.

Under the ADA, an employer must make “reasonable accommodations” for disabled employees, unless such reasonable accommodations would cause an undue hardship to the employer. Disability is defined broadly under both federal and state disability discrimination laws. “In general, an accommodation is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities.” 29 C.F.R. § 1630.2(o). This includes making modifications and adjustments for disabled individuals so they can be considered for positions, perform their job functions and equally enjoy the benefits and privileges of employment. 29 C.F.R. § 1630.2(o).
In the context of late-career practitioners, if a hospital medical staff is concerned about the ability of a practitioner to practice safely, it must undertake an interactive process with the person aimed at finding a way to reasonably accommodate him or her to enable him or her to practice safely. If after a concerted effort to reasonably accommodate the practitioner, the medical staff determines the practitioner still poses a public safety risk, it may then take action against the person without violating the ADA. As with all matters involving discrimination, these cases are viewed on an individualized basis.

It is imperative that due diligence be exercised to be sure that all necessary steps have been completed and documented before acting.

D. **Defending Against a Legal Challenge**

In order to defend a policy against a legal challenge, it is important that the screening required by the policy accurately assesses a physician’s capacity to perform the privileges requested. See Appendix A: Regarding the Evidence of Validity, Predictability, and Reliability.

In order to defend a policy on patient-safety grounds, the age at which the policy goes into effect should have a direct connection to the age at which there is an increased risk of age-related impairments. As such, institutions should monitor the research related to age-related impairments and regularly reassess their policies to ensure that the age the policy goes into effect accurately reflects the current literature on the subject.

As noted above, in order to avoid claims for violation of the ADA, the medical staff must engage in an interactive process with the practitioner and make reasonable accommodations to enable him or her to continue to practice safely, if possible, in light of the results in the reports of the further evaluations performed.

VIII. **Restatement of Purpose**

All of the steps associated with age-related screening of a health care professional have the potential to contribute positively to the safety of patient care as well as to the best interests of the individual practitioner. This document has been prepared as a reference and guide to assist all parties in the process—the individual practitioner and those who prepare, adopt, implement, comply with, and defend policies and procedures for age-related screening. The contents of this document do not replace the judgment of the responsible parties applied to individual circumstances.

IX. **Guidelines and Documents Cited**


California Medical Association Model Medical Staff Bylaws (CMA 2013)
X. APPENDICES

A. APPENDIX A: REGARDING THE EVIDENCE OF VALIDITY, PREDICTABILITY, RELIABILITY OF SCREENING INSTRUMENTS

The purpose of the assessment of cognitive function is to evaluate the practitioner’s capacity to perform the privileges requested, and this requires attention to the choice of the evaluator, the screening instrument(s) used, and the process the evaluator follows.

Screening instruments commonly used are the MicroCog™, St. Louis University Mental Status (SLUMS) Examination, or Montreal Cognitive Assessment. The MicroCog™ is frequently chosen because it is quick to administer and is more well known than other instruments.

Ideally, the screening instrument would be one for which there are published studies conducted with a population comparable to the population of health care practitioners we are working with in this context, but such studies have not been done. For example, the published studies of the MicroCog™ are ones conducted on a general population, not on a population comparable in education level, characteristics and abilities to physicians. Therefore, we rely on the evaluator to interpret the results of the testing in a way that takes these factors into consideration rather than using only the norms from the general population.

The evaluator must factor in the differences between the education-adjusted norm based on the general population and the background and characteristics of the person being tested when the person is a physician. This is one of the reasons for the recommendation that even the first screening assessment of health care professionals be conducted by evaluators who have experience with this population.

Reference:

B. **APPENDIX B: SAMPLE FORMS**

The forms provided here are examples only and may be useful as samples; each institution should design its own forms.

1. **FORM REQUESTING AND REPORTING A MEDICAL ASSESSMENT**

   History and Physical Examination for Late Career Practitioners

**NOTE TO THE EXAMINING PRACTITIONER**

The Medical Staff of XXX, as a part of its efforts to protect both patients and practitioners, requires a comprehensive history and physical examination of practitioners applying or reapplying for clinical privileges beyond a certain age. Important components of this assessment include a review of systems that addresses functional status, and comprehensive sensory examinations including tests of hearing, visual acuity with eye chart and exam, and a thorough neurological exam. The elements of the examination should be modified as appropriate to address the age, clinical condition, medical problems and the clinical privileges requested by the practitioner. *Therefore, please be sure to review the practitioner’s requested privileges before conducting your examination.*

In order to respect the confidentiality of the practitioner’s medical information, please submit only the form attached to this document when sending the results of your examination to the relevant Medical Staff office. As noted on the form, the Medical Staff is interested only in, and should receive a detailed report on only those aspects of the practitioner's health, if any, that have the potential to adversely affect the practitioner’s ability to safely perform the requested privileges or that document his/her ability to do so. You may supply additional information that you feel would be helpful to the Medical Staff in this assessment.

**Practitioner’s Name:**

______________________________

**Requested Clinical Privileges:**

See attached Clinical Privileges Delineation Checklist
History and Physical Attestation Form

I attest that I have performed a comprehensive history and physical examination on this practitioner, and that I have reviewed the clinical privileges requested by this practitioner.

In the history and physical examination the practitioner has no apparent findings that would necessarily preclude him/her from performing the privileges requested.
Agree: ______    Disagree: ______    If disagree, please elaborate below

In tests and studies performed on this practitioner, he/she has no apparent findings that would necessarily preclude him/her from performing the privileges requested.
Agree: ______    Disagree: ______    If disagree, please elaborate below

Do you have any recommendations for further study or evaluation?
No: ______    Yes: ______    If yes, please elaborate below

Additional Comments:

Name, specialty, contact information, and signature of the examining physician:

Name: _________________________________________ Specialty: __________________

Email and phone: ________________________________________________________________

Signature: ___________________________ Date: __________________

Please Fax the completed form to: _________________________________________
2. FORM REQUESTING AND REPORTING A NEUROPSYCHOLOGICAL ASSESSMENT

Cognitive Screening for Late Career Practitioners

NOTE TO THE EXAMINING NEUROPSYCHOLOGIST:

The Medical Staff of XXXXXX, as a part of its efforts to protect both patients and practitioners, requires a cognitive screening evaluation of practitioners applying or reapplying for clinical privileges beyond a certain age.

In order to protect the confidentiality of the practitioner’s medical information, please use only the form attached to this document to submit the outcome of the screening to the relevant Medical Staff office. As noted on the form, the Medical Staff is only interested in, and should only receive a detailed report on, those aspects of the screening, if any, that have the potential to adversely affect the practitioner’s ability to safely perform the requested privileges. You may supply additional information that you feel would be helpful to the Medical Staff in this assessment, including recommendations for further evaluation.

Practitioner’s Name: ______________________________________________________

Requested Clinical Privileges: 
See attached Clinical Privileges Delineation Checklist
Cognitive Screening Attestation Form

I attest that I have administered the cognitive screen requested by the relevant Medical Staff Office to this practitioner and have interpreted the results. I have also reviewed the clinical privileges requested by this practitioner and have taken these into account in my interpretation.

The results of these cognitive screens indicate that the practitioner has no apparent findings that would necessarily preclude him/her from performing the privileges requested.

Agree: ______  Disagree: ______  If disagree, please elaborate below.

________________________________________________

________________________________________________

Do you have any recommendations for further study or evaluation?
No: ______  Yes: ______  If yes, please elaborate below.

________________________________________________

________________________________________________

Additional Comments:

________________________________________________

________________________________________________

________________________________________________

Name, specialty, contact information, and signature of the examining physician:

Name: ___________________________________________ Specialty: ________________

Email and phone: ________________________________________________

Signature: ___________________________ Date: __________________________

Please return the completed form to: ________________________________________
3. **FORM REPORTING A PEER ASSESSMENT**

Confidential Peer Assessment Evaluation Report Form

**APPLICANT NAME:**

The above listed healthcare provider has made application for clinical privileges or practice prerogatives at one or more Name of Medical Center facilities. *Please complete all parts of this form with the check box marked.* If more room is required, please use Comment Section or a separate sheet.

### A. PEER REFERENCE

<table>
<thead>
<tr>
<th>How long have you known the applicant?</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

### B. CLINICAL EVALUATION *(If your evaluation finds an area less than satisfactory in any category, please explain in the comment section or on a separate sheet)*

<table>
<thead>
<tr>
<th>Patient Care: The practitioner provides patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at end-of-life</th>
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</table>

<table>
<thead>
<tr>
<th>Medical / Clinical Knowledge: The practitioner demonstrates knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.</th>
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<table>
<thead>
<tr>
<th>Practice Based Learning Environment: The practitioner uses scientific evidence and methods to investigate, evaluate, and improve patient care practices.</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Interpersonal and Communication Skills: The practitioner demonstrates interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Professionalism: The practitioner demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.</th>
</tr>
</thead>
</table>

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<tr>
<th>Systems Based Practice: The practitioner demonstrates both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.</th>
</tr>
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<table>
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<tr>
<th>Technical &amp; Clinical Skills &amp; Judgment: The practitioner demonstrates the technical and clinical skills and judgment necessary to safely and competently render care, treatment, and service within the scope of privileges requested.</th>
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<table>
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<tr>
<th>History &amp; Physical Exam Taking</th>
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</table>

<table>
<thead>
<tr>
<th>Record Keeping</th>
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<table>
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<tr>
<th>Case Presentations</th>
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</table>

<table>
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<tr>
<th>Patient Management</th>
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<table>
<thead>
<tr>
<th>Practitioner-Patient Relationship</th>
</tr>
</thead>
</table>
Assessing Late-Career Practitioners: Policies and Procedures for Age-based Screening  
A Guideline from California Public Protection & Physician Health / 2015

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand/Speak English</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to Express Him/Herself in Written English</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in Medical Staff functions/committees</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. *PLEASE EXPLAIN ANY YES ANSWERS IN COMMENT SECTION OR ON A SEPARATE SHEET.

<table>
<thead>
<tr>
<th>Confidential Evaluation</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Are you aware of any information that would indicate that the applicant is not able to perform all procedures for which he or she has requested clinical privileges or practice prerogatives, with or without reasonable accommodations required by the Americans with Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients? (NOTE: The Americans with Disabilities Act requires certain reasonable adjustment or modifications to assist disabled individuals in performing their jobs. These are termed &quot;reasonable accommodations.&quot;) If YES, please identify the drug(s) and the time period in which the applicant engaged in such use, including the last date used, if you have such knowledge. If &quot;YES&quot;, has that use interfered with the applicant's professional practice? YES NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Are you aware of any information that indicates that the applicant currently, or in the last year, engages or engaged in the unlawful use of drugs, including the improper use of prescription drugs not under the supervision of a licensed health professional? If YES, please identify the drug(s) and the time period in which the applicant engaged in such use, including the last date used, if you have such knowledge. If &quot;YES&quot;, has that use interfered with the applicant's professional practice? YES NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 During the time noted under Dates of Affiliation on Page 1, are you aware of this healthcare provider ever being subject to any DISCIPLINARY ACTION, such as admonition, reprimand, suspension, termination or voluntary relinquishment of clinical privileges or practice prerogatives?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 To your knowledge, has this applicant ever been investigated or sanctioned because of utilization practices by a peer review organization, government or third party program?</td>
<td></td>
<td></td>
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<tr>
<td>5 Are you aware of any facts regarding him/her which cause you to hesitate in any way in recommending him/her for clinical privileges or practice prerogatives at a Memorial Medical Center facility?</td>
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<td></td>
</tr>
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</table>

D. *PLEASE COMPLETE BY CHECKING THE APPROPRIATE BOXES

<table>
<thead>
<tr>
<th>RECOMMENDATIONS</th>
<th>√</th>
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<tbody>
<tr>
<td>A Recommended as qualified and competent</td>
<td></td>
</tr>
<tr>
<td>B Recommended with some reservation</td>
<td></td>
</tr>
<tr>
<td>C Do not recommend</td>
<td></td>
</tr>
<tr>
<td>D No comment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPORT IS BASED ON:</th>
<th>√</th>
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</thead>
<tbody>
<tr>
<td>A Close personal observation</td>
<td></td>
</tr>
<tr>
<td>B General impression</td>
<td></td>
</tr>
<tr>
<td>C A composite of evaluations by supervisors</td>
<td></td>
</tr>
<tr>
<td>D Other (Please explain in Comment Section or a separate sheet)</td>
<td></td>
</tr>
</tbody>
</table>

*COMMENTS: (Please note strengths/weaknesses, comments regarding clinical privileges or practice prerogatives requested, etc., and explain any answers to above questions)

Date: __________________________ Signature: __________________________
Printed Name & Title: __________________________

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4. **FORM REPORTING OBSERVATIONS FROM NURSING STAFF OR OTHERS IN THE CLINICAL SETTING**

Floor Nursing Manager: Evaluation Of Practitioner Under Evaluation

Confidential Evaluation Form

This evaluation tool is an integral component of the reappointment process for late-career medical staff members of Name of Medical Center and/or Name of Hospital. In an attempt to review the practitioner’s overall performance in all phases of patient care, we would appreciate your participation in completing this evaluation. Professional, confidential discussion of these specific areas with your nursing staff may be of benefit in the accurate completion of this evaluation.

Thank you for your participation and time in assisting us with the reappointment process.

DATE: ______________________________________

Practitioner: __________________ Specialty: __________________

Primary Evaluator: ______________ Phone: ______________

Please evaluate this practitioner in the following areas by placing an “X” in the appropriate boxes below.

<table>
<thead>
<tr>
<th>ACCEPTABLE</th>
<th>UNACCEPTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, verbal and written communication with staff has been clear and timely</td>
<td>☐</td>
</tr>
<tr>
<td>Practitioner consistently responds appropriately to nursing concerns regarding patient status</td>
<td>☐</td>
</tr>
<tr>
<td>Progress notes consistently reflect a clear plan of care and practitioner is involved in discharge planning efforts</td>
<td>☐</td>
</tr>
<tr>
<td>Practitioner consistently responds to pages in a timely manner</td>
<td></td>
</tr>
<tr>
<td>Patient and significant others seem cognizant of health care issues and practitioner’s proposed treatment plan</td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS: __________________________________________________________

__________________________        Please Print Name                __________
Signature, Nursing Manager                              Date

QUALITY ASSESSMENT RECORDS ARE NON-DISCOVERABLE UNDER CALIFORNIA EVIDENCE CODE 1157 AND ALL EVALUATION FORMS SHOULD BE KEPT IN MEDICAL STAFF SERVICES UPON COMPLETION. ONCE COMPLETED, PLEASE DO NOT KEEP A COPY. THANK YOU.

3/11 EVAL FORM NURSING FLOOR MGR
C. **Appendix C: Model Medical Staff Bylaws**

This appendix presents exemplar language, shown in italics, for relevant portions of a medical staff bylaws to support and implement the policies discussed in this document. The California Medical Association’s Model Medical Staff Bylaws have been used as a sample solely for illustrative purposes. Please note that CMA has not adopted any of the exemplar language into its model bylaws, and other model or actual medical staff bylaws may vary slightly.

**DEFINITIONS**

**INVESTIGATION**

*The language should note that activities of the Wellbeing Committee do not constitute investigation.*

**Nondiscrimination**

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, or sexual orientation *that does not pose a direct threat to patient safety or the quality of patient care.*

**Qualifications for Membership**

Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on professional training, experience and current competence criteria as set forth in these bylaws.

**General Qualifications**

Only physicians, [dentists] [podiatrists] [clinical psychologists] shall be deemed to possess basic qualifications for membership in the medical staff . . . . and who,

- Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, including satisfying age-based screening and assessment as may be applicable, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive safe, quality medical care;

**Application for Membership and Membership**

**General**

Except as otherwise specified herein, no person shall exercise clinical privileges in the hospital unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws. By applying to the medical staff for initial membership or renewal of membership, the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Membership on
the medical staff shall confer on the member only such clinical privileges as have been granted in accordance with these bylaws.

Effect of Application
By applying for membership or renewal of membership on the medical staff, each applicant:

(a) Signifies willingness to appear for interviews in regard to the application;
(b) As may be applicable, agrees to satisfy age-based screening and any reasonable follow-up assessment requested by the Wellbeing Committee;

CREDENTIALS COMMITTEE
Composition
The credentials committee shall consist of not less than [ ] members of the active staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the staff departments.

Duties
The credentials committee shall:

(a) review and evaluate the qualifications of each practitioner applying for initial membership, renewal of membership, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the Wellbeing Committee and other appropriate departments; * * * *

WELLBEING COMMITTEE
Composition
The Wellbeing Committee shall be comprised of no less than [ ] active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of [ ] years, and the terms shall be staggered as deemed appropriate by the executive committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

Duties
The Wellbeing Committee may receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action.
The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities.

The committee shall also develop and implement a uniform policy for age-based screening and assessment of applicants for and members of the medical staff. The purposes of the policy shall be to protect patient safety, to safeguard the rights and privileges of practitioners and to provide support for aging practitioners. The Wellbeing Committee may consult with legal counsel for the medical staff for assistance. Any policy and amendments or modifications thereto shall be approved by the medical staff [OR MEDICAL EXECUTIVE COMMITTEE] in accordance with procedures established in these bylaws.

At a minimum, the policy must:

1) Provide that the Wellbeing Committee is charged with conducting age-based screening and any follow up assessments as reasonably necessary but shall have no authority to take disciplinary action or any action related to privileging, but will report its findings to the Credentials Committee;

2) Specify that the requirement for age-based screening and assessment be based solely on the age of a practitioner and applies equally and uniformly to all applicants for and members of the medical staff who have reached the specified age;

3) Specify the age at which age-based screening and assessment shall begin to apply. The age requirement shall have a direct connection to the age at which there is an increased risk of age-related impairments, as documented in the scientific and medical literature. The Wellbeing Committee shall regularly monitor the research related to age-related impairments and modify the policy for age-based screening and assessment as appropriate;

4) Establish the frequency with which reassessments are required for reappointment of practitioners above the specified age;

5) Determine who pays for the costs of the age-based screening and assessment in a manner that minimizes undue burden on the individual practitioner while also ensuring efficacy and stability of the age-based screening and assessment program;

6) Establish protections and confidentiality of all documents and information about a practitioner undergoing age-based screening and assessment, with appropriate exceptions for the protection of patients. The Wellbeing Committee shall develop a standard release form to permit evaluators’ reports to be shared with the Wellbeing Committee;

7) Establish criteria for identifying and using qualified evaluators; and

8) Specify the consequences that may be taken if a practitioner unjustifiably fails to cooperate with the age-based screening and assessment program.
D. **APPENDIX D: WELLBEING COMMITTEES**

*Guidelines for Physician Well-Being Committees Policies and Procedures* (CMA On-Call Document #5177 September 2013) describe the role and function of wellbeing committees for medical staffs according to The Joint Commission Standards. The Committee provides a source of expertise whereby the medical staff may identify health factors underlying a clinical performance problem for which corrective action is under consideration. In the context of a formal investigation regarding clinical performance being conducted by the Medical Executive Committee or similar entity within the organization, the Well-Being Committee may be called upon to determine the presence, and the nature, of an underlying problem and make recommendations related to such problems.

An “individual health” or well-being function is mandated by the Joint Commission and is implemented by a committee of the medical staff. According to Standard MS.11.01.01, a medical staff must implement “a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes.”
E. APPENDIX E: FREQUENTLY ASKED QUESTIONS

1. DO HIPAA PROTECTIONS APPLY TO THE REPORTS OF THE SCREENING OR THE FULL EVALUATIONS?

The Privacy Rule set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects all "individually identifiable health information," which can become "protected health information" (PHI). The question of HIPAA’s application to health information received in a screening evaluation or other examination may change depending upon the legal relationship between the physician and the entity requesting the evaluation. For employed physicians evaluated by their employer, HIPAA defines PHI to EXCLUDE any health information in employment records held by a covered entity in its role as employer. [45 CFR Section 160.103] “Employment records” isn’t defined, but the Department of Health and Human Services has clarified that medical information needed for an employer to carry out its obligations under the Americans with Disabilities Act and similar laws, as well as files or records related to fitness for duty tests, are part of employment records and not subject to HIPAA. Secondly, California law has special provisions that apply to employers’ use and disclosure of employee health information [Civil Code Section 56.20].

In the context of a hospital medical staff that performs screening of physicians as part of its privileging process, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. Health care operations include competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation.

It should be noted that HIPAA and state confidentiality laws contain numerous limitations and exceptions to the use and disclosure of PHI and this document is not in any way intended to neither provide legal advice nor speak to the application of HIPAA and state confidentiality laws in specific instances.

The best way to avoid any potential confidentiality issues is to require physicians to sign a waiver of their privacy rights under HIPAA or state law. It should be noted, however, that the rules regarding an appropriate consent under HIPAA and state law also contain certain conditions and limitations. Counsel should be consulted for assistance and guidance in creating consent documents.

2. WHAT IS THE RELATIONSHIP BETWEEN AGE-BASED SCREENING AND A FITNESS FOR DUTY EVALUATION?

The results of a screening assessment are used to learn whether there are areas of health or abilities that require further evaluation in order to determine whether they affect performance. “Age-based screening” in a medical staff, for example, is conducted for all persons when they reach a certain age regardless of any other factors such as health or performance. If the
information from a screening assessment raises a question about the evaluatee’s health and abilities, further evaluation is needed before conclusions or recommendations can be developed.

The term “fitness for duty evaluation” describes an evaluation or set of evaluations comprehensive enough to allow the evaluator to make observations and recommendations about whether the evaluatee’s health and abilities are sufficient to allow him/her to perform the duties of his/her role and function safely.

A fitness for duty evaluation is different from a clinical evaluation in that the focus is not on diagnosis or illness, but on ability to perform current duties. If the purpose of an evaluation is to determine fitness for duty, the report must include focused observations and conclusions of the evaluator about whether, and if so how, the evaluatee’s health and abilities support or do not support the safe practice of his/her role and duties.

3. **WHAT MUST BE REPORTED TO THE MEDICAL BOARD OF CALIFORNIA AND THE NATIONAL PRACTITIONERS DATA BANK?**

California and federal law require reports to be filed with the Medical Board of California (MBC) and/or the National Practitioner Data Bank (NPDB) whenever action taken by a peer review body results in denial of an application, suspension, restriction or loss of medical staff privileges or employment. Under Business and Professions Code Section 805, the denial of an application for appointment or reappointment, or the suspension, restriction or loss of medical staff privileges or employment, must be for a “medical disciplinary cause or reason.” Any restriction imposed or voluntarily accepted must remain in effect for a cumulative total of 30 days or more within a 12-month period. A summary suspension must be reported after it has been in effect for 14 consecutive days. Summary suspension requires that the peer review body determine that the failure to take action immediately may result in imminent danger to the health of any individual.

A report must also be filed pursuant to 805 when a physician resigns, takes a leave of absence, or withdraws or abandons an application for appointment or renewal while under investigation for a medical disciplinary cause or reason. Business and Professions Code section 805 defines medical disciplinary cause or reason as “that aspect of a licentiate’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.”

The Healthcare Quality Improvement Act (HCQIA) of 1986 42 U.S.C. Section 11133 requires healthcare entities to report any professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days. A “professional review action” is defined in 42 USC Section 11151(9) as an action or recommendation of a professional review body “which is based on the competence or professional conduct (which conduct affects or could affect adversely the health and welfare of a patient or patients).”

HCQIA further requires that healthcare entities report the surrender of a practitioner’s clinical privileges while under investigation relating to possible incompetence or improper conduct or in return for not conducting such an investigation or proceeding.
The Medical Board of California must submit the information received from the healthcare entity to the NPDB within 15 days of the date it was received (45 C.F.R. Section 60.5(c)).

In the context of age-based screening of late-career practitioners, the questions related to reporting depend entirely upon the specifics of the situation, and state laws will differ in their reporting requirements. We do not believe that a routine age based screening examination as part of an application for appointment or reappointment constitutes an “investigation for medical disciplinary cause or reason” as defined in Section 805 or an investigation relating to incompetence or improper conduct under HCQIA. If a routine physical, cognitive or peer review-based evaluation reveals information that creates concerns regarding the practitioner, the question of whether the action taken by the peer review body is a reportable action under state or federal law will depend upon multiple variables and the steps taken to address the concerns. Not everything a medical staff or physician group might do in response to concerns raised during a screening examination will constitute a reportable event and this task force urges that the focus be upon physician wellbeing as opposed to discipline. For example, actions taken by the practitioner on the recommendation of the Wellbeing Committee in which the practitioner takes the initiative to limit his/her own privileges or status should not be considered disciplinary actions. If, however, actions of the peer review body or professional review body are required in order to place limits on the privileges or status of the practitioner because of quality of care concerns, reporting statutes must be followed.

Physicians and hospitals should consult their bylaws and seek guidance from counsel if questions arise in responding to any concerns generated by a positive finding in an evaluation.
F. **APPENDIX F: REFERENCES**


G. APPENDIX G: LEGAL ASPECTS OF AGE-BASED SCREENING

Given the demographic trends, clinical evidence and public discussion, there are legitimate concerns among institutions that the failure to employ mechanisms to better identify providers manifesting early physiologic and cognitive changes may put patients at risk and subject hospitals and physician groups to liability for failing to address the issue. Most prevalent has been the question of whether age-based screening policies should be added to the extensive network of peer review, quality assurance/performance improvement, impaired physician policies, and physician wellbeing programs already in place to assist physicians and fulfill the obligations of institutions to ensure quality. One of the primary barriers to implementation of age-based screening requirements is the concern that such measures conflict with well-established age and disability discrimination laws at both the federal and state levels. For better or worse, healthcare institutions were not among the multiple professions for which exceptions were created by Congress, the courts and industries for mandatory hiring and retirement ages and medical examinations based on age.

The AMA estimates that only 5-10% of hospitals have implemented policies which vary between combinations of physical examinations, cognitive examinations and focused peer review for clinicians that reach a particular age. Some require testing at age 70 and others 75. Others include shorter reappointment periods for practitioners beginning at 70 or 75. We are unaware of any hospitals contemplating an age limit for granting privileges to physicians practicing on their medical staffs. In contrast to hospitals, mandatory retirement policies for physician groups are not at all uncommon. Mandatory retirement ages of 65 and 70 are present in many physician group agreements accompanied by mechanisms that allow a practitioner to continue practicing under certain circumstances. Most notable is that California has included an exception in its age discrimination statute that allows physician groups to retire physicians at age 70.?

1. THE EVOLUTION OF AGE DISCRIMINATION LAWS

a) LEGISLATION

Federal and state age discrimination laws have followed a very different path than laws prohibiting workplace discrimination based on race, religion, national origin, gender and sexual orientation. Notwithstanding decades of discussion of the impact of mandatory retirement of employees at age 65 by employers, age discrimination was not included in the landmark 1964 Civil Rights Act which outlawed discrimination in the workplace. Congress demanded that the issue of age discrimination be studied further because it was viewed as different from other forms of invidious discrimination. The difference resided in the recognition that conditions associated with age can impact job performance in ways that endanger the employee, others in the workplace or the general public. In 1967, Congress ultimately passed the Age Discrimination in Employment Act (“ADEA”).

In the ADEA, Congress declared it “unlawful for an employer to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions or privileges of employment, because of such individual’s age”. Despite this

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7 See California Government Code Section 12942(c).
sweeping statement, Congress saw no contradiction in establishing laws in the years surrounding passage of the ADEA which mandated retirement for certain professions, including: pilots at age sixty\(^8\) (1959); air traffic controllers at age fifty-six (1972); and federal law enforcement and firefighters at age fifty-five (1974). Additional mandatory retirement ages were established in subsequent years for nuclear materials couriers, customs and border protection officers, the Central Intelligence Agency, and the Federal Bureau of Investigation.\(^9\) All of these policies rested on concern for the public.

The difference in the way age was viewed is also reflected in the evolution of the scope of the ADEA’s protections. Originally, the law applied only to employees between the ages of forty and sixty-five. It was amended in 1978 to extend the upper age to seventy, and then again in 1986 at which time Congress removed the upper age limit completely. Because the 1986 amendments extended protection to all workers over forty, Congress was lobbied to include exceptions. In particular, the 1986 amendments allowed institutions of higher education to impose compulsory retirement for tenured faculty and educators at age seventy (this was eventually eliminated in 1993)\(^10\); and allowed companies to retire “highly paid executives” at age 65 under certain prescribed conditions. Most significantly, Congress took no action to eliminate the mandatory retirement and screening requirements for pilots, air traffic controllers, law enforcement and others.

States have also evolved in their treatment of age discrimination legislation. It was not until the past decade that all states had passed statutes prohibiting discriminatory practices based on age. Like Congress, states have their own exceptions in their statutes as reflected in California Government Code Section 12942(c).

b) The Treatment of Age Discrimination in the Courts

Initially, courts applied a very deferential standard in reviewing age-based hiring and retirement policies in the airline, bus and law enforcement contexts. The policies were defended on the grounds that individualized testing and monitoring of job performance was inadequate to protect against catastrophic health related events, particularly in the context of mass transportation. The assumption was that age increased the probability of such events and that no amount of testing could rule out a sudden stroke, cardiac event or other incapacitating condition. In these early cases, the courts asked only whether the legislature or industry had a rational basis for believing that hiring and retirement at a particular age were appropriate proxies for a system of individualized testing. They further focused on admissions by experts testifying for those challenging the policies that testing could not completely eliminate the risk of a catastrophic event.

Over time, courts have become more demanding of legislatures and industries to demonstrate that age-based measures are necessary and superior to individualized testing and monitoring. One of the mechanisms adopted by the courts scrutinizing these policies is to closely examine the job functions involved. Thus, while courts have accepted the mandatory retirement age requirements for commercial pilots, a policy mandating retirement for flight engineers was rejected by a court. The court felt that the airline and FAA could not demonstrate the same degree of risk to passengers

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\(^8\) See 49 U.S.C. § 44729.
\(^10\) See 29 C.F.R. § 1625.11.
posed by a sudden medical event with an engineer as compared with an event involving a captain. Similarly, a court rejected an age-based retirement policy applied to a fire chief whose job functions were not viewed by the court as the same as front line firefighting personnel.

As alluded to above, there are important cautionary notes to be advanced in looking at the judicial treatment of age discrimination claims. Primary among them is that almost all of the cases adjudicating age-based restrictions involve mandatory hiring or retirement policies, not age-based screening. While there are clearly concerns with abuses that might arise from medical screening, one gets the sense that mandatory hiring and retirement policies are perceived by courts to create greater harm because the result is to definitively deprive the worker of the ability to pursue his or her chosen field. Courts in many cases have based their holdings against arbitrary age limitations for hiring and retirement on the ground that individualized testing was available, reliable and more consistent with the underlying values of protecting workers from discriminatory practices.

2. **Elements of a Physician Claim of Age Discrimination**

While there is a scarcity of cases dealing with the implementation of age-based policies in healthcare, there are numerous cases involving claims of age and other forms of discrimination by physicians against academic institutions, hospitals and physician groups. These cases involve allegations by individual physicians that age, disability or some other type of discrimination was the motivation for an institution’s termination or restriction of their employment or medical staff privileges. These cases provide guidance on the application of the required elements of discrimination claims to physicians and thus provide insight into the legal doctrines that would govern a claim against an age-based policy. This is particularly meaningful in the context of medical staff actions given the basic requirement that age and disability discrimination laws apply only in the employment relationship.

a) **The Employee vs. Independent Contractor Element**

The ADEA and Title VII of the 1964 Civil Rights Act apply only to employers and employees, not independent contractors. Where a claim for age or other form of discrimination under Title VII is brought by an employed physician, this element is satisfied. In the context of a physician claiming discrimination by a hospital medical staff against his or her privileges, however, courts have more often than not concluded that the physician is an independent contractor, thereby precluding the claim. These cases have recognized that medical staff membership is inherently one in which the hospital is not exercising control over the physicians diagnosis and treatment of patients and thus does not fit the definition of an employment relationship.

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11 Kuck v. Bensen, 647 F.Supp. 743 (D. Me. 1986) (emergency room physician not an employee in ADEA challenge to the reduction of emergency room privileges); Vakharia v. Swedish Covenant Hosp. 190 F.3d 799 (7th Cir. 1999) (anesthesiologist not an employee under Title VII and the ADEA in challenge to termination of her hospital medical staff privileges); Bender v. Suburban Hosp., Inc., 159 F.3d 186 (4th Cir. 1998) (physician not an employee under Title VII in gender discrimination claim against hospital that denied her medical staff privileges); Alexander v. Rush North Shore Medical Center, 101 F.3d 487 (7th Cir. 1996) (physician not an employee in Title VII action against hospital for alleged discriminatory termination of staff privileges); and Shah v. Deaconess Hosp., 355 F.3d 496 (6th Cir. 2004) (surgeon not an employee in ADEA and Title VII action challenging termination of his surgical privileges).
There are other cases, however which render this question less clear. The *Salamon v. Our Lady of Victory* case is a prime example. In *Salamon*, the Court used a manner-and-means test to determine whether the physician was an “employee” of the hospital. The Court focused on whether the hospital had the right to control the “manner and means” by which the physician accomplished her work at the hospital. The Court determined that analysis of any employment relationship is fact-specific, and that each case requires scrutiny of the specific relationship between the parties. Staff privileges alone did not decide Salamon’s employment status. The court held that it could not determine as a matter of law that the physician plaintiff was an independent contractor and allowed that question to be submitted to the jury.

Courts have also created a test which focuses on the *effect* of the hospital’s action as opposed to the relationship between the physician and the medical staff. Specifically, courts have allowed physician’s to proceed with discrimination claims if the hospital’s actions interfered with the physician’s employment opportunities with third parties. By focusing on the question of interference, courts have opened an avenue for physicians challenging medical staff actions that might otherwise have been foreclosed by the employer-independent contractor analysis.

b) **THE BONA FIDE OCCUPATIONAL QUALIFIED QUALIFICATION (“BFOQ”) DEFENSE**

Title VII and the ADEA permit employers to engage in what might otherwise be considered discriminatory hiring and discharge policies where the policy or practice is based on a “bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.” It is this exception that allows for religious institutions to hire employees of their religious affiliation; for prisons to hire only male guards in “contact” areas of a maximum security prison; for weight and physical fitness requirements for paramedics; and for positions which require contact with individuals that require privacy. The BFOQ defense does not apply in the case of race or disability discrimination.

Laws, regulations and industry policies have survived judicial scrutiny in many cases because the courts have agreed that age can serve as a bona fide qualification under certain circumstances. In cases examining the BFOQ defense in claims of age discrimination, courts conduct a case-by-case analysis examining the specific job at issue; the risks to the employee or public associated with the job; the specific age or age range in the policy; the consequence of the policy (e.g., retirement); and the evidence as to the necessity of using the specific age in the policy in the circumstance before the court. Most relevant is the common theme that the presence of legitimate safety concerns, particularly to the public, lessens the burden required to defend an age-based policy.

As set forth above, the health care industry has simply not been the focus of either legislation or court cases examining age-based policies, thereby leaving a great deal of uncertainty as to how a policy might fare in a BFOQ analysis. It is clear however, that patient safety is the overwhelming driver of the examination of the utility and need for age-based screening of providers and would play a major role in any arguments before the courts.

3. **DISABILITY DISCRIMINATION LAWS**

The question of age-based testing also implicates laws which prohibit discrimination based on an individual's disability. The federal American’s with Disabilities Act (“ADA”) and Rehabilitation Act of
1973, as well as state laws prohibiting disability discrimination, impose restrictions on an employer’s ability to inquire regarding medical conditions and to deny an individual the right to work based on a disability. Unlike age discrimination laws which might preclude a physician’s claim against a medical staff because the physician is not an employee, the courts have held that Title III of the ADA does apply in the medical staff context.

a) **SCREENING EXAMS**

Generally speaking, an employer or medical staff can, and must, take a physician’s health into account in both the hiring and privileging process. Disability discrimination laws do not expressly preclude disability related inquiries nor medical screening examinations. Rather it places certain limits on the stage at which health related inquiries can be made, and the scope of any inquiry. According to the EEOC, “[t]he ADA’s provisions concerning disability-related inquiries and medical examinations reflect Congress’s intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can efficiently perform the essential functions of the job.”

An employer may make disability related inquiries and require a medical examination only if they are “job related and consistent with business necessity.” A disability-related inquiry or medical examination of an employee is “job-related and consistent with business necessity” when an employer “has a reasonable belief, based on objective evidence, that: (1) an employee’s ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition. Periodic medical examinations and other monitoring under specific circumstances may be job-related and consistent with business necessity.

Employers may also require periodic examinations of employees in positions affecting public safety such as police officers and firefighters. Where examinations are required by safety regulations, an employee cannot assert an ADA claim as barrier to employer compliance with regulations. Equally important are court cases which have held that physicians and other providers may not seek protection of disability discrimination laws where the provider poses a direct threat to the health and safety of other individuals in the workplace. The term “direct threat” is defined in this section to mean “a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.”

The determination of whether an employee poses a direct threat must be based on “an individualized assessment of the individual’s present ability to safely perform the essential functions...”

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12 See Joint Commission Comprehensive Accreditation Manual for Hospitals, MS.06.01.05(6).
13 EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000).
http://www.eeoc.gov/policy/docs/guidance-inquiries.html
14 EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000).
http://www.eeoc.gov/policy/docs/guidance-inquiries.html
15 EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000).
http://www.eeoc.gov/policy/docs/guidance-inquiries.html
16 42 U.S.C.§ 12113(b); 42 U.S.C.§ 12182(b)(3).
17 42 U.S.C.§ 12111(3).  See also Sch. Bd. of Nassau Cnty., Fla. v. Arline, 480 U.S. 273 (1987).  It is worth noting that the definition of direct threat in the EEOC’s regulations adds additional language to the ADA’s definition. The regulation states that a direct threat is “a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation.” 29 C.F.R. § 1630.2(r).  (Language added to the regulation is in bold).
of the job,” which itself must be based on “a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence.” This assessment should consider four factors: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm.

b) REASONABLE ACCOMMODATION

The final question here relates to the actions which are available should a screening exam reveal some form of process causing or potentially contributing to an impairment. Under the ADA, an employer must make “reasonable accommodations” for disabled employees, unless such reasonable accommodations would cause an undue hardship to the employer. Disability is defined broadly under both federal and state disability discrimination laws. “In general, an accommodation is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities.” This includes making modifications and adjustments for disabled individuals so they can be considered for positions, perform their job functions and equally enjoy the benefits and privileges of employment.

In the context of late-career practitioners, if a hospital is concerned about the ability of a physician to safely practice medicine, it must undergo an interactive process with the physician aimed at finding a way to reasonably accommodate him or her to enable him or her to practice safely. If after a concerted effort to reasonably accommodate the physician, the hospital or physician group determines the physician still poses a public safety risk, it may then take action against the physician without violating the ADA. As with all matters involving discrimination, these cases are viewed on an individualized basis and it is imperative that caution be exercised to be sure that all necessary steps have been completed and documented before acting.

4. DEFENDING AGAINST A LEGAL CHALLENGE

In order to defend a policy against a legal challenge, it is important that the screening required by the policy accurately assesses a physician’s capacity to perform the privileges requested. See Appendix A: Review of the Evidence of Validity, Predictability, Reliability.

In order to defend a policy on patient-safety grounds, the age at which the policy goes into effect should have a direct connection to the age at which there is an increased risk of age-related impairments. As such, institutions should closely monitor the research related to age-related

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18 29 C.F.R. § 1630.2(r).
19 29 C.F.R. § 1630.2(r).
20 29 C.F.R. § 1630.2(o).
21 29 C.F.R. § 1630.2(o). The ADA regulations set forth three categories of reasonable accommodations: “(i) modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires; or (ii) modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position; or (iii) modifications or adjustments that enable a covered entity's employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities.” 29 C.F.R. § 1630.2(o)(1)(i-iii).
impairments and regularly reassess their policies to ensure that the age the policy goes into effect accurately reflects the current literature on the subject.

In order to avoid claims for violation of the ADA, the medical staff must engage in an interactive process with the practitioner and make reasonable accommodations to enable him or her to continue to practice safely in light of the results in the reports of the further evaluations performed.

Appendix G was prepared by Richard Barton, Jamie Quient and Natalie Mueller of the firm Procopio, Cory, Hargreaves & Savitch LLP in San Diego.

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