

Graying Gracefully in the Medical Profession?¹

By: Amy J. McCullough, Esq., *Polsinelli*

One in four U.S. physicians is older than 65², and physicians between the ages of 65 and 75 account for 11% of the active workforce.³ By comparison, in the specialty of vascular surgery, approximately 40% of physicians are over the age of 55.⁴ The median retirement age for physicians generally is approximately 68 years old.⁵ Many physicians over the age of 56 indicate plans to retire in the next 1-3 years due, in part, to the changes in the health care delivery system,⁶ decline in reimbursement, increased regulatory compliance, and implementation of electronic medical records and other technologies.⁷

Unlike other professions such as airline pilots (mandatory retirement age of 65) and FBI agents (mandatory retirement age of 57), typically, physicians do not have mandatory retirement ages.⁸ However, physicians are not exempt from the aging process. Data indicates that when physicians, like any other person, reach their 60s and 70s, a significant and progressive decline in their cognitive and physical skills results (e.g., hand tremors; dementia).⁹ The important distinction for physicians is that these health deficits can have a negative and potentially life-threatening impact on patient care. Not only can the outcome negatively impact a patient's well-being but can destroy years of hard-earned professional reputations and careers. Real-life examples of physicians with health deficits include a distinguished vascular specialist in his 80s who performed surgery, went on vacation forgetting that he had patients in the hospital which ultimately resulted in patient death due to the absence of physician oversight.¹⁰

As you plan progressively in your career, you can take proactive steps to protect yourself, your career, and your patients as you age to avoid negative (and often times, incorrect) assumptions by others of potential health deficits that may or may not exist. This article summarizes issues commonly faced by aging physicians and how hospitals are dealing with such issues and what you and private practices can do to address such issues.

Issues Commonly Faced by Aging Physicians

Adapting to Change in Health Care Delivery

Older physicians are no longer practicing medicine in the same health care environment as when they started their careers. Technologies are changing and treatment approaches are changing along with them. Many older physicians who practiced during a different time and culture may be

¹ This Article is for informational purposes only. The material provided herein is general and is not intended to be legal advice. Nothing herein should be relied upon or used without consulting a lawyer to consider your specific circumstances, possible changes to applicable laws, rules and regulations and other legal issues. Receipt of this material does not establish an attorney-client relationship.

² AMA Staff Writer, *Competency and Retirement: Evaluating the Senior Physician* (June 23, 2015), available at <https://wire.ama-assn.org/ama-news/competency-and-retirement-evaluating-senior-physician> (last accessed on February 7, 2017).

³ IHS, Inc., *2016 Update, The Complexities of Physician Supply and Demand: Projections from 2014 to 2025* (April 5, 2016), available at https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf (last accessed on February 7, 2017).

⁴ Meritt Hawkins, *The Aging Physician Workforce: A Demographic Dilemma* (2015), available at https://www.merrihawkins.com/uploadedFiles/mhwhitepaper_aging.pdf (last accessed February 7, 2017).

⁵ *Id.*

⁶ Japsen, Bruce, Forbes, *More Doctors to Retire as MACRA and Value-Based Pay Hit* (September 21, 2016), available at <http://www.forbes.com/sites/brucejapsen/2016/09/21/more-doctors-to-retire-as-macra-and-value-based-pay-hit/#684b23154261> (last accessed February 8, 2017).

⁷ *Id.*

⁸ Boodman, Sandra, *Aging Doctors Face Greater Scrutiny* (December 10, 2012), available at <http://khn.org/news/aging-doctors-face-greater-scrutiny/> (last accessed February 7, 2017).

⁹ Furci, Patricia, RN, MA, Esq. et al., *Modifying Practice for Age, Health, or Impairment* (May 2015), available at <http://www.hcpro.com/content/314869.pdf> (last accessed February 7, 2017).

¹⁰ *Id.*

resistant to adopting new technology, maintain preferences for outdated medical techniques that may result in higher risk or lower success rates, struggle with technological advancements including, the required use of electronic health records, and struggle with keeping up with the new pace of work-flow demands. Many may be facing cognitive and physical impairments that they don't acknowledge or realize which potentially impact the safety and quality of care provided to their patients.

How are Aging Issues Being Addressed?

Hospitals

Hospitals are required to engage in active oversight of the quality of care rendered by physicians practicing in their facilities (e.g., Joint Commission accreditation requirement). To meet such obligations and to ensure their patients receive high quality of care from their growing population of older physician providers, hospitals are taking various approaches to address potential cognitive and physical deterioration of abilities that may result from the aging process.

Hospitals address this issue in various ways, including treating aging physicians in the same manner as other medical staff members by relying on existing credentialing and peer review processes to identify any quality of care concerns of aging physicians and other medical staff members to intervene when they see a colleague show potential deficiencies. Many hospital medical staffs include wellness/impairment committees and provisions or requirements in their medical staff bylaws that allow the medical staff to ask or require mental and physical evaluations of medical staff members. The challenge in this approach is that many of these existing processes are not adequately identifying issues and/or colleagues are hesitant to report their peers who may be struggling.

Mislabeling as “Disruptive”

Aging physicians who are either employed by, or medical staff members of, hospitals are potentially at-risk for also being labeled a “disruptive physician.” In recent years, hospitals and medical staffs have used the peer review process to label a physician “disruptive” (e.g., overt actions such as outbursts and physical threats, refusing to perform assigned tasks)¹¹ merely for expressing concerns about patient care or otherwise “annoying” a hospital administration.¹² If a hospital does not have an aging physician policy in place but has a “disruptive” physicians policy or medical staff bylaw provision in place, older physicians may be vulnerable to being labeled as “disruptive” by hospitals as a means to push older physicians out and not due to any true quality of care or patient safety concerns.

Physicians need to be aware of such policies and ensure that they are adequately protected particularly if an adverse action (e.g., loss of privileges) is taken against the physician under the guise of violating the hospital's “disruptive” physician policy.

Consequently, a growing number of hospitals are amending medical staff bylaws and/or implementing policies that impose mandatory competency testing (implemented by, for example, a “wellness committee”) after a certain age. Many physicians object to such policies because aging varies by individuals – simply hitting a certain age does not, in and of itself, mean that the physicians' competency has deteriorated.

¹¹ See Joint Commission: Sentinel Event Alert, *Behaviors that Undermine a Culture of Safety* (Issue 40, July 9 2008), available at https://www.jointcommission.org/assets/1/18/SEA_40.PDF (last accessed February 8, 2017).

¹² Leiker, Michelle, *Sentinel Events, Disruptive Behavior, and Medical Staff Codes of Conduct*, 108 Wis. Med. J. 333 (2009).

Additionally, many of these types of policies are legally challenged. Physicians may file suit against an employer such as a hospital or physician practice based on employment-related claims for age or disability discrimination under, for example, Title VII, the federal Age Discrimination in Employment Act (“ADEA”), and the American Disabilities Act of 1990 (“ADA”).

Several courts have held hospitals liable under Title VII¹³, ADEA¹⁴, and the ADA.¹⁵ Although we note many hospitals have successfully defended ADEA claims by demonstrating the age-based testing program is “reasonably necessary” for public safety¹⁶ (which is determined by a court on a case-by-case basis by looking at factors such as the specific job, risks to the employee or public, specific age or age range in the policy, the consequence of the policy (e.g., retirement), and necessity for use of the a specific age in the policy).¹⁷

For example, Stanford Hospital in Stanford, California has implemented a “Late Career Practitioner Policy” which requires physicians over the age of 74 ½ who are applying for privileges and physicians over the age of 75 who seek to renew their privileges to undergo testing as a condition of receiving or maintaining admitting privileges at the hospital.¹⁸ The assessment is mandated by the policy and includes a peer assessment of the physician’s clinical performance and physician and cognitive screenings.¹⁹ If the results of the exams indicate patient care concerns, the physician may be subject to further evaluation and could have his/her clinical privileges restricted, limited, or revoked (subject to his/her due process rights to a hearing and appeal under the hospital’s medical staff bylaws).²⁰

The American Medical Association (“AMA”) as well as the American College of Surgeons²¹ support age-based screenings to evaluate physicians’ mental health and review of their treatments of patients.²² The AMA’s Council on Medical Education is currently developing guidelines and standards for monitoring and assessing physician professional competency based on age.²³ Additionally, as of 2016, the American College of Surgeons (“ACS”) recommends surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician for overall health assessment starting at age 65 to 70.²⁴ The ACS also recommends that surgeons voluntarily access their neurocognitive functions using confidential online tools and reminds physician of their professional obligation to voluntarily self-disclose any concerning and validated findings.²⁵

¹³ See Lowe, Michael R., *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees Under Title VII and the ADA Act When Alleging an Employment Discrimination Claim?*, 1 DePaul J. Health Care L. 119 (Fall 1996).

¹⁴ See *Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening, A Guideline from California Public Protection and Physician Health, Inc.*, Appendix G (2014).

¹⁵ *Id.*

¹⁶ Page, Leigh, *Should Doctors Be Tested for Competence at Age 65* (October 28, 2015), available at http://www.medscape.com/viewarticle/848937_9 (last accessed February 6, 2017).

¹⁷ See *infra* note 18, Appendix G; see also Lowe, Michael R., *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees Under Title VII and the ADA Act When Alleging an Employment Discrimination Claim?*, 1 DePaul J. Health Care L. 119, 158-59 (Fall 1996).

¹⁸ See Jacobson, Rachel, *Age-based Testing of Physicians: Best Practices Age Discrimination?* (March 18, 2013), available at <http://www.lexology.com/library/detail.aspx?q=f48b0662-3024-494c-a797-97b171a79cb1> (last accessed February 6, 2017).

¹⁹ *Id.*

²⁰ *Id.*

²¹ American College of Surgeons, *Statement on the Aging Surgeon* (January 1, 2016), available at <https://www.facs.org/about-acs/statements/80-aging-surgeon> (last accessed on February 7, 2017).

²² See *infra* note 1.

²³ Farouk, Amy, *AMA News, Key Stakeholders Explore Assessment of Aging Physicians* (March 22, 2016), available at <https://wire.ama-assn.org/ama-news/key-stakeholders-explore-assessment-aging-physicians> (last accessed February 8, 2017).

²⁴ See *infra* note 21.

²⁵ *Id.*

Private Practices

As private practices experience an increase in their physician members reaching retirement age, practices may consider implementing a formal written policy or approach outlining how the practice will deal with potential aging physician issues such as deteriorating hearing or other cognitive and physical abilities. Practices may consider implementing an age-based policy that includes a mandatory retirement age or mandatory assessment of cognitive and physical fitness after physician members and other healthcare practitioners reach a certain age (e.g., 65 years old and annually thereafter). Mandatory retirement policies may create potential issues since age-related decline may vary by individual. Such a policy could result in a negative impact on the practice by limiting access to experienced physicians particularly in rural or underserved areas, as well as alienating its aging physicians.

If an age-based policy is implemented, the policy should include:

- Clear purpose and rationale for the policy.
- Clear statement that the policy applies to all health care practitioners of the practice.
- Set forth the type of assessment required (e.g., cognitive, physical, general health), frequency of such assessment (e.g., beginning at age 65 and annually thereafter or upon an incident or complaint that warrants an assessment), and who is to perform the assessment (e.g., independent physician engaged by practice and mutually agreed upon).
- Specify who pays for the assessment (e.g., practice pays; physician and practice share costs).
- Specify the consequences if a practitioner refuses or fails to be evaluated (e.g., termination of employment or buy-out of ownership interests).

Not all physicians want to work past age 65. Thus, practices should also consider adopting retirement policies and/or plans for their retiring physicians.

The retirement plan or policy should address:

- Compensation benefits (including “tail” coverage).
- Whether the physician will remain in a consultant role or other part-time role with the practice and terms associated with such role (e.g., compensation, hours, etc.).
- Notification to patients, including any notices required under applicable state law.
- Notification to the medical board(s) and other agencies and associations.
- Retention of medical records in compliance with federal and state law.
- Transition of patients (e.g., to other physician members of the practice).

Additionally, particularly for larger practices, governance documents (e.g., operating agreements) may require amendments to address voting requirements, compensation benefits for retirement, and other operational issues related to retirement and aging physicians.

To avoid potential legal claims such as claims under Title VII, ADEA, and ADA by aging physicians, practices should ensure that any age-based policy implemented has a direct connection to the age at which an increased risk of age-related impairments exists which will require a monitoring of research related to the same; communicate and work collaboratively with physicians to determine a reasonable policy that achieves both parties’ goals and the ultimate goal of ensuring patient safety so as to avoid physicians feeling “forced” into retirement or undervalued; and ensure that the parties mutually work to implement reasonable accommodations (as necessary) to allow for the continued practice of the aging physician based

on any assessments performed (e.g., reduced case load, limited duties, reassignment of certain duties or roles, and/or reduced call requirements after a certain age is reached).

Proactive Protective Measures

As a physician, some proactive protective measures to consider include: (1) getting a physical every year; (2) consider obtaining a neuroevaluation or neuropsychology evaluation on a routine basis; (3) not self-medicating if an issue exists or arises; (4) implementing a checks and balances system with trusted colleagues so that you keep each other accountable; and (5) seeking professional guidance and help if an issue arises/threatens to arise rather than trying to address the issue yourself.

Conclusion

For many physicians, practicing medicine is not just what they do, but who they are. Thus, it is important for all health care providers – whether hospitals or private practices – to cautiously and respectfully approach this sensitive subject by carefully planning in advance how to address the realities of our aging physician population without devaluing or undervaluing the careers built and wisdom provided by these physicians.

McCullough is a shareholder at Polsinelli PC. She counsels physicians, physician practices, and health care technology clients in transactional, regulatory, administrative law, and litigation matters on a national basis. Contact McCullough at 404.253.6058 or ajmccullough@polsinelli.com. For more information on Polsinelli's Health Care Practice, visit: <http://www.polsinelli.com/services/healthcare>.