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Senior Physicians: Addressing Age, Ability and Acumen

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Editor's Note: This special theme section evolved from the Rhode Island Medical Society's regional conference on Senior Physicians: Addressing Age, Ability, and Acumen held in September 2016. The symposium was arranged by the RIMS Physician Health Program and made possible by an educational grant to RIMS from the Coverys Community Healthcare Foundation.

Just a year ago the Rhode Island Medical Society (RIMS) and the Physician Health Program (PHP) convened a full-day symposium about senior physicians and their ability to continue to practice. Well over 100 people attended. Four papers in this issue reflect the variety of subjects presented.

Doctors (at any age) who are observed to be forgetful or have other manifestations of cognitive impairment should be referred for medical evaluation and cognitive testing. Mild cognitive impairment or early dementia that would mandate retirement from patient care may be documented.

Current opinion is that routine cognitive screening of all doctors over a certain age is not likely to be useful. Because of the variability of test results in a population of "high achievers" such testing is not likely to be an accurate independent predictor of whether a doctor should continue to practice. Several screening programs have ceased age-based routine cognitive testing. A detailed exploration of this subject will be presented in a paper to be published in a future issue.

Whether doctors are competent to practice is a decision made by the Board of Licensure and these regulatory issues are reviewed in the paper by Dr. McDonald.

The PHP recently evaluated two senior doctors.

Doctor A was referred because of poor prescribing practices. There was no other evidence of cognitive impairment such as forgetfulness, etc. though he made a "poor impression" during an initial interview with a committee. This resulted in his referral to the PHP. He was leading an active and productive life. The question of whether he was providing acceptable, quality care would not be answered by cognitive testing. The appropriate method of evaluation would be an audit of his practice to determine directly the quality of his care and this was arranged.

Doctor B was referred because many observers agreed that his clinical care was substandard. He also was noted to be forgetful. Cognitive testing did not reveal significant abnormalities. Thinking that this doctor may have had very

high cognitive function previously and that the current test was part of a "downhill" process, the cognitive testing was repeated two years later and it was marginally improved!

The lesson: if the question is whether a doctor of any age, in the absence of a suspected impairing illness, is competent to practice, the best way to find out is to evaluate the quality of his patient care directly.

If an impairing illness of any type is suspected, that issue should be resolved as a part of the medical and cognitive evaluation before doing a formal practice audit. It is important to note that normal age-related changes may not impair a doctor's ability to practice if they are recognized. Drs. Minter and Besdine review these issues in their paper.

If a practice audit reveals that patient care is not acceptable, a thorough physical and cognitive evaluation should be undertaken to ascertain whether there is a treatable illness as a cause.

Thus, screening of apparently healthy older doctors is best done by directly evaluating the quality of their patient care. Doctors who practice in large groups are more easily evaluated than those who are in solo practice. Whether screening can be limited legally to older doctors is discussed in the article by attorney Chase-Lubitz.

There is, however, no age restriction on planning for retirement – in fact the earlier one thinks about this, the better. See the discussion by Donna Singer.

The symposium generated discussion about what the next step might be. The result is a task force convened by RIMS with representation including hospitals, government, cognitive scientists, FAA examiners, PHP members, lawyers, medical staffs, chief medical officers and others. It was quickly realized that the discussion must address all age groups and the effort really is a "Patient Safety Initiative." Currently this is a work in progress.

The articles published in this special section of the *Rhode Island Medical Journal* offer the reader a good background in these issues and perhaps some insight into one's own attitude and plans for retirement. And we wish you well on that journey.

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The Aging Physician

JAMES V. McDONALD, MD, MPH

The practice of medicine, perhaps the noblest of professions, can be one of extremes. Daily in the clinical spaces where we engage in our art, matters of life, death, joy and sadness are common. As we reflect on our career, perhaps another extreme is the anxiety, excitement and expectation of the first day of medical school contrasted with the anxiety, excitement and expectation of the last day we engage in this noblest of arts.

We are all getting older and leaving our profession is a difficult and emotional topic to address. Some of us look forward to retirement, some of us can not envision retirement at all, yet all of us want to leave this profession on our own terms. No one wants to be removed from this profession due to quality of care concerns, competency issues or health issues.

Rhode Island like other states has a physician population that is getting older. Data from the Rhode Island Department of Health reveal 16% of physicians are older than 60.

Data from the 2012 AMA Masterfile report certain specialties in Rhode Island have >40% of its physicians over 60 including, Anatomic and Clinical Pathology, Endocrinology, Diabetes and Metabolism, Otolaryngology and Radiology and Diagnostic Radiology.¹ The Federation of State Medical Boards reports in a 2014 census of physicians that nationally, 31% of physicians are older than 60.²

Aging is normal and quite frankly preferred. Aging has attributes that are expected and physicians are not exempt from normal aging. There are cognitive implications and declines in certain abilities such as processing speed, visuospatial orientation, language, some types of memory and executive functions.³ Normal aging is distinct from dementia and Alzheimer's disease which is associated with a progressive functional cognitive decline and also increase in prevalence with age.⁴

There is another side to aging, particularly in physicians, which reflects the profound wisdom, experience and clinical judgement that come from years of practice. There is no substitute for the presence of a sage wise physician in every practice and the patient benefit and safety that flows from their accessible consultation. The practice of medicine has a well-established tradition of physicians training physicians and sharing our wisdom and knowledge benefits everyone.

Professional societies have not been silent on the issue of the aging physician and agree the time has come for

this issue to be more thoroughly addressed. The American Medical Association (AMA) is exploring the possibility of competency testing for older physicians.⁵ *"Physicians are professionally obligated to continually assess their own physical and mental health, even though there is no national standard for screening physicians who have reached a certain age. But a number of other professions that can impact public safety do have age-related cutoffs in place. Commercial airline pilots, for instance, must be regularly screened beginning at age 40 and must retire at 65."*

The American College of Surgeons (ACS) has also explored the issue of the aging physician and issued a statement in January of 2016.⁶ The ACS statement encourages surgeons to maintain a healthy lifestyle, recognize they are not immune to the changes of aging and also that the surgeon might not recognize their own deterioration of skills.⁷ The ACS took their recommendations further and recommended between the age of 65 and 70 surgeons voluntarily have physical and visual health evaluated as a baseline as well as ongoing. Additionally, ACS states: *"Colleagues and staff must be able to bring forward and freely express legitimate concerns about a surgeon's performance and apparent age-related decline to group practice, departmental and medical staff, or hospital leadership without fear of retribution."⁸*

It is evident that these two professional organizations recognize the gravity, complexity and emotional aspects of this issue. It is also evident no simple solution is apparent to such a complex issue. The issue of the aging physician is complex and does require engagement from several stakeholders regarding a way forward. Issues surrounding employment, regulatory responsibility, patient safety, physician autonomy, right to work are just a few that need to be explored. We have before us an opportunity to work together on this important public health, physician wellbeing and patient safety issue.

All of us are reminded we are able to practice this profession for a season of our life and our time in this season is an opportunity and a gift. This is a gift that should be treasured and yet we do need to plan for a lifetime after our season of service has concluded. It would be ideal to arrive in our golden years with both the gold and the years to enjoy them, and do so our own terms.

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Cognitive Decline in Physicians and their Patients

BRADLEY MINTER, MD; RICHARD W. BESDINE, MD

The average age of licensed practicing physicians in the United States has risen from 50 in 2010 to 52 in 2014; 26% are over 65 years of age.¹ Given the increased demand healthcare faces in both number and complexity of patients, it is important to consider factors that contribute to a physician's career longevity. Often focus is on strategies to prevent burnout during a practitioner's career. However, here we will discuss evidence-based steps that can be taken to prevent cognitive decline in aging practitioners, thus preserving the workforce.

Over time, examination of the aging nervous system undergoes predictable changes, such as in muscle tone, increased postural sway and postural hypotension, and decreased arm swing. This is an abbreviated list, but these peripheral and motor phenomena are irrelevant to clinical performance of those physicians that do primarily brain work. However, there are cognitive changes that can be seen in healthy aging. Physicians may wonder about these changes, and whether they are going to affect their ability to practice medicine. In healthy aging, varying degrees of reduced processing speed, free recall, multitasking ability and attention span can be expected. Fortunately, these changes, in the absence of actual disease states, are not expected to affect a physician's job performance or shorten a physician's career. Furthermore, learning strategies can be implemented that are effective in enhancing the encoding and the accessing of new and old information. Because new cognitive obstacles occur in a non-uniform manner throughout the older population, individualization of assessment and intervention is key.² Intervention strategies, such as mnemonics, mental hierarchies and clusters, which are used less by elders than when they were younger, give long-lasting improvements when implemented. Distractions also interfere more in elders than the young. In practice, instructions to older patients should be given directly, and in a manner than can be easily encoded to increase adherence and outcomes.

The good news is that domains which are arguably the most important to career longevity are resilient in pure aging. Short-term memory, also known as immediate recall, persists. Long-term memory is relatively spared, with very good procedural memory – e.g., biking, knots, music – and semantic memory, meaning facts. Episodic long-term memory declines with age, making remembering location, time, and memory of events difficult. Applying learned strategies discussed above can help if these changes become problematic. Pathologic cognitive decline, feared more than death by many older adults, is a different story. But here, too, is mostly

good news. In observational studies, high levels of education and continuing work that demands thinking and reasoning with learned information are protective against Alzheimer's disease (AD) (the most common dementia worldwide).

It is very important to distinguish the cognitive changes of normal aging from the pathologic basket of dementia, which is defined as an acquired disorder producing a decline in memory and other cognitive domains sufficient to affect daily life in a previously normal adult. Diagnosis is made when progressive cognitive and functional decline are noticed, usually by family first, in a patient without any sensory deficits – such as need for a hearing aid or cataract surgery. Memory impairment plus one of four other cognitive deficits are required for diagnosis: *apraxia*, trouble with motor planning; *aphasia*, trouble with language; *agnosia*, a sensory processing deficit; or disturbances in *executive functioning*. Delirium, a distinct transient entity, must not be present and be ruled out by thorough medical evaluation.

The largest proportion of those diagnosed with dementia have AD, which is notable for its gradual onset and steady progression. Although recent work has indicated that the incidence of AD has been in decline, demographic shifts in the age of our population will result in continuing increases in the number of afflicted persons. The U.S. senior population is expected to grow from 43 million in 2012 to 92 million in 2060; with that growth, the prevalence of dementia is expected to rise from 4.7 million in 2010 to 13.8 million in 2050.³ The costs associated with this change are projected to exceed \$1 trillion by 2050.

Being the 5th or 6th leading cause of death in the United States, AD shortens life expectancy at time of diagnosis by 6.7 years in a 60-year-old, and 1.9 years in a 90-year-old.⁴ These mortality data should be a factor in clinical decision-making. Goals of care discussions should begin early and often in patients with dementia, once the patient and family understand the course of the disease.

Early diagnosis is important for social, medical and financial decision-making, but is often hindered by the insidious presentation and course of the disease. When identified early, disease burden can be mitigated by planning for the future decline while the patient still retains decision-making capacity and can participate in the process. Complaints of elders related to normal psychomotor slowing of aging can confound the challenges of screening for cognitive status in elders, but also make it more important. A patient with memory complaints of misplacing car keys, difficulty with word and name recall, and worrying about memory should

be given reassurance and education regarding learning strategies. Family complaining a patient never remembers the correct word, loses the car keys, makes major financial mistakes, has poor insight regarding memory loss, and repetition of conversations should trigger evaluation for dementia. Occasionally, the first sign leading to a diagnosis of a pathologic cognitive impairment is failure to perform at one's job. As a physician, development of a neurodegenerative condition such as AD would indeed be career ending. Our field has a unique system judging for competence to practice, in which we are all responsible to ensure no harm is being done to our patients and are required to report when we think harm could be done. It is important to remember that this is not driven by age but by performance.

When considering protecting the physician workforce from cognitive decline, one should consider the fixed and modifiable risk factors for AD. Fixed risk factors for AD classically include age, family history, female gender, and Down Syndrome; more recently identified risk factors are apolipoprotein E4, history of herpes simplex encephalitis, and history of depression. Modifiable risk factors include risks for stroke (e.g., hypertension, smoking, atherosclerosis, dyslipidemia, obesity, and diabetes) physical inactivity, depression and low level of education. Perhaps the best first step that protects cognition that most clinicians have already completed is decades of education and the cognitive demands of clinical practice. A recent study that followed subjects for 10 years revealed those who engage in craft activities, computer use, playing games, and social activities had significantly decreased incidence of mild cognitive impairment.⁵ One could suppose that those benefits are already reaped by practicing physicians, given the complexity of daily clinical activities.

But demanding brain work should not excuse ignoring other modifiable risk factors for the development of AD, given the recently identified associations of certain behaviors with prevention of cognitive decline. Healthy diet, regular frequent exercise and minimizing stroke risk factors are a great start. A study monitoring subjects based on their level of physical activity through mid- and late life showed that moderate exercise at any frequency was associated with decreased incidence of mild cognitive impairment.⁶ Unfortunately, careers in medicine do not make prioritization of daily exercise easy, but we hope this association will motivate us.

A Mediterranean diet supplemented with olive oil or nuts has been shown to prevent acute myocardial infarction, stroke or death from cardiovascular events.⁷ Recent analyses from the same study has shown improved cognition.⁸ Guidelines of 2016 suggest a mix of vegetables, whole fruits, whole grains, fat-free dairy, a variety of protein, including nuts and unspecified oils.⁹ These evidence-based recommendations targeting modifiable risk factors to protect the aging brain from cognitive impairment and the development of AD are not going to protect us all, as the non-modifiable risk factors can overcome even the healthiest among us. Given the high stakes, taking these protective steps seems worthwhile. Employers often recommend their employees consider diet and exercise as a part of maintaining a healthy, stress-reduced

work force. Adding preserved cognition in aging to that list may help motivate additional healthcare providers.

In summary, there are cognitive changes associated with normal aging that are not expected to affect one's ability to practice medicine. There are learning strategies one can adopt to improve brain function during aging, and most physicians are likely to want to adopt them. Importantly, data confirm that lifestyle modification is associated with decreased incidence of developing mild cognitive impairment and subsequent AD, a diagnosis that would require retirement and end-of-life planning similar to a late stage malignancy.

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Legal Issues and the Aging Physician

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INTRODUCTION

Competency, knowledge, and experience are fundamental to quality care in the practice of medicine. Although aging physicians may show increased signs of poor competency, the medical community recognizes the high variability of the effect of age on physicians. Despite the complex correlation between aging and cognitive changes, the potential for danger to patient safety pushes the demand for improved methods of identifying declining competency in physicians. There is currently no law regulating competency assessment of the aging physician community. A host of legal considerations relevant to tangential issues exist, but there is no doctrine, no protocol, and no treatise specific to aging physicians and their ability to provide quality medical care. This article will explore the issues of age-based competency assessment (i.e. screening) in three contexts – physician as employee, physician as a member of a facility medical staff, and physician as licensee of a state medical authority – where issues of physician competency are most likely to arise.

EMPLOYMENT CONTEXT

When a physician serves as an employee in a health facility, questions concerning his competency due to advanced age will be examined through two prisms of established employment law: age discrimination and disability discrimination.

The federal Age Discrimination and Employment Act (ADEA) and corresponding law in all fifty states prohibit the arbitrary use of age in decisions that impact the employment status of individuals. The ADEA, when passed by Congress and later amended, carves out a bona-fide qualifications exemption so certain occupations deemed to be of such importance to public safety may mandate a reasonably necessary retirement age. For example, pilots are required to retire at age 65; air traffic controllers at age 56; federal law enforcement and firefighters at age 57; and nuclear material carriers at age 57. Congress has never felt compelled to apply a mandatory retirement age to physicians.

Initially, as various industries outside of those covered by the federal mandate were sued under the ADEA (and similar state statutes) for implementing age-based hiring and retirement policies thought to be discriminatory, courts deferred to arguments that individualized testing and monitoring were inadequate to protect against catastrophe. The courts' test for examining the imposed retirement age was: Does the

industry have a rational basis for holding that an age cut-off was an appropriate substitute for case-by-case testing? The answer typically was "yes".

More recently, however, courts began scrutinizing actual job functions to determine if across-the-board age restrictions were superior to individualized testing. This has led to a trend in which courts have based their holdings against age-triggered hiring and retirement policies on the fact that individual testing and monitoring were available and reliable – and that such individualized testing better protects the employee from discriminatory practice.

We have yet to see a case in which a court analyzed a mandatory retirement age policy of a health care employer on the basis of employment discrimination. If we did, the court would likely reject arguments that the general protection of public health demands implementation of a pre-determined retirement age for physicians. Rather, courts are more likely to support the use of screening mechanisms, for which age may be one of several factors, that rely on testing and monitoring and take into account the particular conditions of the physician whose competency is in question.

The second prism through which to analyze age-based competency in the employment context is disability discrimination. The federal Rehabilitation Act of 1973 and Americans with Disability Act (ADA), and state disability discrimination laws, prohibit adverse employment activities based on an individual's disability. Under the ADA, an employer may inquire about health conditions and require a medical examination only when they are "job related and consistent with business necessity." The employer must have a reasonable belief based on objective evidence that the employee's ability to perform essential job functions will be impaired by a medical condition, or that the employee will pose a direct threat to others as a result of that medical condition. Determining whether an employee poses a direct threat must be based on an individualized assessment of the employee's present ability to safely perform the essential functions of his/her job.

Age itself is not a disability under the ADA. Rather, an individual is deemed to have a disability if he/she (i) has a physical or mental impairment that substantially limits one or more major life activities, (ii) has a record of such impairment, or (iii) is perceived by others of having such impairment. Given the breadth of the definition it is difficult to conceive of a situation in which a health care employer's

initiation of an age-based competency assessment will not implicate the physical or mental impairment of the physician employee or, at a minimum, evidence that the employer perceives its physician employee suffers from such impairment. In turn, if the employer is subject to the ADA, then any request for a screening of the physician will have to meet the standards stated above (i.e., reasonable belief that essential job functions are impaired or poses direct threat to others). The employer will then be required to obtain an individual medical examination of the physician. In sum, one should not look to the disability laws for support of generally applied age-triggered screening. To the contrary, disability jurisprudence stands for the idea of case specific, individualized assessment.

MEDICAL STAFF CONTEXT

Many physicians associate with health care enterprises not through an employment relationship, but as an independent member of a facility's medical staff – most commonly exemplified by a community physician's credentialed position at his/her local hospital. As such, these medical staff physicians generally do not enjoy the protection of the age and disability discrimination laws discussed in the prior section because those laws apply in almost all cases only to the employment relationship. Hence, a health care institution has significant latitude to develop policies and rules that govern its relationship with its independent (i.e. non-employed) medical staff members – including the implementation of age-based competency screening. There have been cases in which physicians have argued that the controls and oversight inherent in the medical staff relationship are significant enough to create an employment relationship between hospital and physician. If successful, those arguments could cause the wholesale application of the age and disability discrimination statutes to facility medical staffs. As courts are extremely reticent to qualify medical staff members as anything other than independent contractors, the application of the discrimination laws to medical staff members is highly unlikely.

As noted, disability discrimination laws generally apply only in the employment context. However, there is one federal circuit that has held medical staff privileges to be protected from disability discrimination under Title III of the ADA. In that case, a doctor's suspension from the medical staff was deemed to be a denial of privileges of a physical "place of public accommodation," bringing the matter under Title III. In this particular case, the physician's alleged disability was Attention Deficit Disorder. If this federal circuit court had been asked (or is asked in the future) to review a physician's medical staff suspension due to a neurological impairment (perhaps resulting from advanced age), the court may very well find that the physician's privileges are subject to the ADA and that the physician's employer is subject to the full set of ADA standards for requesting of the physician any type of medical assessment. Barring the limited exception

of possible ADA Title III application, the use of age-based screening in the review of a physician's clinical privileges by a health care facility medical staff is generally permitted.

STATE LICENSURE CONTEXT

As the primary bodies charged with licensing and disciplining physicians, state medical licensing boards maintain the ultimate responsibility for ensuring that their physician licensees provide competent services to the public. The courts, all the way up to the U.S. Supreme Court, have repeatedly recognized the authority of state licensing bodies to regulate the practice of medicine as a means to protect the public health. In the 1889 case, *Dent v. West Virginia*, the Supreme Court stated:

"Few professions require more careful preparation by one who seeks to enter it than that of medicine. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. Due consideration, therefore, for the protection of society may well induce the state to exclude from practice those who have no such a license, or who are found upon examination not to be fully qualified."

In the case of age-based competency screening, if a state licensing board determined that such screening was a necessary tool to protect the public health (and ensured due process protections to those individuals' subject to screening), courts would likely reject any challenge thereto. State licensing bodies, already established with the infrastructure to review questions of professional competency and to respond to the particular conditions of their licensees by way of practice restrictions, mandated supplementary education and oversight requirements, are undoubtedly in the best position to undertake age-based screening.

PROTECTION OF SCREENING RESULT

Age-based screening tests will by necessity involve medical information in assessing the competency of a physician's skills. Understandably, professionals may respond with concerns regarding the confidentiality of the testing results. If the screening is conducted in the employment context, the Health Insurance Portability and Accountability Act (HIPAA) will not afford protection to medical information obtained during the test because HIPAA does not protect employment records. The confidentiality of these records will be subject to employer policy and state employee-protection law. In the medical staff context, test results from screening pursuant to a competency protocol may be deemed a product of peer review activity and protected accordingly. Most state peer review statutes protect the confidentiality and admissibility of peer review documentation. The challenge here is that the scope of peer review activities, and thus the scope of the protection, varies significantly state to state. Finally, if the screening were to take place under

the authority of a state licensing board, the results would be subject to the treatment provided them by the laws and regulations governing the activities of the board. Many states mandate the confidentiality of their investigations into professional competency, and while the final results or findings of a licensing board review are made public, the work product (including screening results) typically is not.

CONCLUSION

As the medical and legal communities develop their responses to the practical aspects of age-based competency screening, the legal framework around the issues of the aging physician will come into focus. We saw under the first section above that the general practice of age-based screening is anathema to the protections afforded employees under established employment discrimination laws. Facility medical staffs provide much greater latitude for implementing screening protocol. The result, however, of having individual health facilities develop age-based competency reviews is likely to be diverse and inconsistent screening programs applied only to limited subgroups of physicians (i.e., those who are members of a medical staff). Resting the screening process on public health concerns and requiring all physicians licensed to practice within a state removes extrinsic biases that may occur at the level of an employer or medical staff age-based screening test. Implementing an age-based screening test as a part of the licensing process at the state licensing board level also would best adhere to the courts' emphasis on the state's expansive authority in protecting the general welfare of its citizens.

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Moving Forward: Retirement Opportunities for Senior Physicians

DONNA SINGER, MS

As national and local medical organizations explore how to assess senior physicians and their competence and skill, it is important for physicians to understand that retirement can be an exciting, interesting, and significant life stage in and of itself. Many opportunities may exist – both within and outside of health care – to allow these physicians who no longer practice, to continue to live meaningful and satisfying lives. Toward that end, it may be helpful for hospitals and other health care organizations to provide lectures, seminars, and small group discussions related to retirement in order to reduce the fear that professional life may definitely be over once one leaves clinical practice.

Also while still practicing clinical medicine, some physicians may want to develop a plan as to what they will do next. Others may want to retire first and perhaps have a period of rest and relaxation for a few months before thinking about or planning how to spend the rest of their time/lives.

Each physician needs to retire in the way that works best for him or her. Yet, if observations and/or assessments indicate that one must leave clinical practice before realizing this on his or her own, the situation may be daunting.

When most people think about retirement, specific words or concepts immediately come to mind such as:

- Extended down time
- Boredom
- Lonely time
- Financial considerations
- Relaxation and fun
- Writing
- Traveling
- More family time

It is clear from the above, that there is no one attitude about retirement. Moreover, there is no one model of retirement. Jawaharlal Nehru said, "We live in a wonderful world that is full of beauty, charm, and adventure. There is no end to the adventures we can have if only we seek them with our eyes open." These adventures for a retiring physician may involve travel or may be right at home.

In today's world, retirement may turn out to be twenty or more years. Therefore, living with meaning, passion, and purpose will be important for well-being and longevity.

The following activities may be helpful for physicians, as they plan for the future:

Activity 1 – My Current Reality

(*While still in clinical practice*)

Using percentages (%), how much of my time do I currently spend in each of the following areas?
(Total should add up to 100%).

- Paid work
- Leisure activities
- Family
- Friends
- Health/Self-care
- Personal growth
- Spirituality
- Financial matters
- Living environment
- Voluntary activities
- Other:
.....

Activity 2 – Envisioning the future

(*When I am retired*)

Using percentages (%) when I retire, how much of my time would I like to spend in each of these areas?
(Total should add up to 100%).

- Paid work
- Leisure activities
- Family
- Friends
- Health/Self-care
- Personal growth
- Spirituality
- Financial matters
- Living environment
- Voluntary activities
- Other:
.....

Activity 3 – Learning from what has worked

Another activity that has proven to be helpful in envisioning the future is called Appreciative Inquiry. This technique helps you to understand what has worked for you in the past and therefore what might be a direction for you in the future. Four questions that may prove helpful are:

- What first attracted you to medicine as a career?
- What energized you in the early days of medical practice?
- As you think back on your career to date, what could you say was a special moment when you felt most alive, involved, and excited about your work?
- What, if anything, might your answer to question #3 tell you about ways you might be engaged in your retirement, in medicine or other areas?

Activity 4 – Reflection

Schedule a time and select a place to have a “meeting” with yourself. Think back to the time before you decided on a career in medicine. What subjects in school did you excel in? What subjects or extra curricula activities did you enjoy most? If you hadn’t become a physician what other career(s) might you have been interested in pursuing? If you have family members or friends who knew you pre-medical school, ask them what, if any, career they think you would have enjoyed and been successful in.

Activity 5 – Interviewing colleagues and friends

Contact colleagues and/or friends who have been retired for at least a couple of years, and ask them these questions and questions of your own:

- What is your typical day like?
- What were the first six months of retirement like for you?
- What have been your three greatest joys in retirement?
- What have been your three greatest challenges in retirement?
- How have you integrated your personal and “professional” life in your retirement?
- What advice or suggestions would you give to a physician who is thinking about retiring?

You may want to keep a notebook with what you’ve learned from these interviews. Perhaps you’ll discover that the individuals you interview will really enjoy the opportunity to share their experience with an interested person such as you.

Moving Forward: Retirement Opportunities

Many physicians have found one or more of the following options satisfying, rewarding, and/or stimulating after leaving a long career in clinical practice:

Within health care: Teaching medical students as a volunteer, teaching abroad, volunteering in a clinic locally,

volunteering in a clinic in another country, committee work in a medical society, committee work in your hospital or organization, writing about issues or concerns in health care, lecturing, consulting, expert witness, working in a pharmaceutical company, tutoring individual medical students.

Outside of health care: (Following an interest or passion – previous or new) Performing in a musical group (voice or instrument), learning to play an instrument, joining a chorus or choir, studying music history, taking art lessons, visiting museums, studying art history, writing articles, writing a blog, writing a novel, writing a memoir or family history, studying genealogy, travel in the United States, travel abroad, visiting specific local historical sites, travel for pure adventure, travel for learning, beginning an exercise program, learning and engaging in a new or different sport, combining travel with exercise (walking trips or bicycle trips), participating in a marathon, visiting family, family travels and vacations, caring for grandchildren, organizing family reunions, learning to cook, going to a cooking school, taking cooking classes, learning about healthy eating.

Any one of the above activities either in health care, related to health care, or completely separate from health care, could be developed into what is known as an encore career. This next career might be strictly as a volunteer, or could be a paid engagement.

Physicians may be surprised to realize how many different opportunities there are for meaningful engagement after clinical practice. Not all of the above activities are sufficient to totally satisfy one’s emotional, social, or learning desires; more than one can be engaged in at the same time. However, it’s important not to become so busy that work-life balance once again becomes a challenge.

A Role for Hospitals and Health Care Organizations

Hospitals and other health care organizations can play a major role in helping all senior physicians look forward to retirement regardless of their age, ability and acumen. Physicians who are suddenly advised not to practice clinically any longer or are actually told they may not practice any longer can find themselves despondent and worried. Realistic yet positive presentations by hospitals or health care organizations about this next life stage – with guest speakers, seminars, and discussion groups – can be quite helpful. Even former clinical “stars” returning to tell about their experiences since retiring can be reassuring to those who fear the loss of identity after so many years as a clinician.

The message is clear: there is meaning in life after full-time clinical practice. Those individuals who enter this life phase with a positive attitude, in spite of a variety of challenges – perhaps physical and/or cognitive challenges – will find meaning and feel energized and productive. Knowing the many possibilities available to senior physicians after clinical practice will hopefully help with this transition.

Interesting Books Related to Retirement

The Encore Career Handbook, How to Make a Living and a Difference in the Second Half of Life

Marci Alboher

80 Things to Do When You Turn 80

Mark Evan Chimsky, Editor

Live Smart after 50!

The Experts' Guide to Life Planning for Uncertain Times

Life Planning Network Editorial Board

Legacies of the Heart, Living a Life That Matters

Meg Newhouse, PhD

Time-shifting, Creating More Time to Enjoy Your Life

Stephan Rechtschaffen, MD

70 Things to Do When You Turn 70

Ronnie Sellers, Editor

The Couple's Retirement Puzzle, 10 Must-Have

Conversations for Creating an Amazing New Life Together

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