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 by 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 to 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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