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Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory?

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Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory?

Ilene N. Moore†

Abstract

In the U.S., one out of eight practicing physicians is older than sixty-five, and many practice well into their seventies. Many commentators and healthcare organizations, concerned that aging physicians are at risk for cognitive impairment, have urged, or actually instituted, cognitive "screening" for older physicians as a means to ensure patient safety. An age-based screening program, however, should not proceed unless supported by clear evidence and not prohibited by law.

This article argues that neither of these conditions applies. Singling out all older physicians for cognitive testing is empirically unjustified and legally prohibited. Furthermore, there are other means to reliably monitor and identify physicians, both older and younger, who pose risk to patients. Legally, two federal statutes prohibit age-based screening. According to the Age Discrimination in Employment Act of 1967 (the "ADEA"), age-based screening constitutes prohibited discrimination because it is based on unsupported stereotyping about age and imposes a burden on one set of employees while overlooking others. According to the Americans with Disabilities Act of 1990 and the ADA Amendments Act of 2008 (collectively, the "ADA"), age-based screening constitutes prohibited discrimination because an employer is only permitted to require medical examination when it has

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reasonable belief that an individual has a condition that could interfere with job performance or the individual poses direct threat to others. The consequence of both these statutes is that hospitals cannot go on a “fishing expedition” and conduct en masse screening of their older medical staff; they can only examine those whom they have reason to believe may be impaired or otherwise dysfunctional. The article concludes by discussing processes and methodologies that facilitate identification of physicians of any age who may warrant further assessment. By enabling hospitals to identify physicians of all ages who pose risk to patient safety in a way that aligns with the principles of the ADEA and ADA, they can strike the appropriate balance between fostering patient safety and not discriminating against one physician demographic.

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Introduction

The U.S. health care system relies heavily on older physicians. Currently, one of eight practicing physicians is older than sixty-five, the traditional age of retirement.¹ Some practice well into their seventies or beyond.² Many commentators and health care organizations find this trend concerning and have urged or instituted,³ cognitive "screening" for

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1. See, e.g., AM. MED. ASS'N, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE US. AMERICAN MEDICAL ASSOCIATION. (Table 1.1) (Derek R. Smart ed., 2015) (citing 2013 statistics).
 2. See Aaron Young et al., *A Census of Actively Licensed Physicians in the United States, 2016*. 103 J. MED. REG. 7, 10 (2017).
 3. See John Sanford, *New Policy to Require Evaluations for Late-Career Practitioners*, STAN. MED. July 16, 2012, <https://med.stanford.edu/news/all-news/2012/07/new-policy-to-require-evaluations-for-late-career-practitioners.html> (Stanford Medical Center has since dropped its plan to institute cognitive screening). The following hospitals reportedly conduct some form of age-based screening: Driscoll Children's Hospital (Texas) and the University of Virginia Health System. see Sara Stankorb, *Out of Practice*, PROTO MAG (Jun 10, 2015), <http://protomag.com/articles/out-of-practice>, and Jewish Hospital and Saints Mary and Elizabeth Hospital

older physicians. Their argument is rooted in a perception that aging physicians threaten patient safety.⁴ This perception springs from several sources. One is the increasing prevalence of cognitive impairment with age in the general population,⁵ leading to the concern that some older physicians are affected but undiagnosed.⁶ Another is the belief that members of the medical community sometimes fail to intervene in cases of observed impairment.⁷ Moreover, screening proponents

in Louisville, Kentucky and Portsmouth Regional Hospital in New Hampshire. Leigh Page, *Should Doctors Be Tested for Competence at Age 65?*, MEDSCAPE (Oct. 28, 2015), <https://www.medscape.com/viewarticle/>.

4. Page, *supra*, note 3 ("Proponents of age-based testing say it's no longer permissible to simply allow aging physicians to determine when they should retire, because many of them stay on after impairment sets in.").
5. W. M. van der Flier & P. Scheltens, *Epidemiology and Risk Factors of Dementia*, 76 J. NEUROLOGY. NEUROSURGERY & PSYCHIATRY v2, v3 (2005).
6. See, Richard Hyer, *Cognitive Impairment in Older Physicians May be Widespread*, MEDSCAPE MED. NEWS (2005). (While some estimate the number of cognitively impaired physicians based on the general population, there is little research in this area. A geriatrics specialist stated that he had "no idea what the prevalence" is of those "who remain in practice."); Sheila M. LoboPrabhu et al., *The Aging Physician with Cognitive Impairment: Approaches to Oversight, Prevention, and Remediation*, 17 AM. J. GERIATRIC PSYCHIATRY 445, 453 (2009) ("Collecting more data on the aging physician with dementia is imperative . . . There is a dearth of information about the numbers . . .").
7. See, e.g., Joy Daughtery Dickinson, *As Surgeons Age, Are They Putting Your Program at Risk?*, AHC MEDIA (Apr. 1, 2013), <https://www.ahcmedia.com/articles/63084-as-surgeons-age-are-they-putting-your-program-at-risk>; Laurie Tarkan, *As Doctors Age, Worries About Their Ability Grows*, N.Y. TIMES, (Jan. 24, 2011), <http://www.nytimes.com/2011/01/25/health/25doctors.html?pagewanted=all&r=0>; Sandra G. Boodman, *As Doctors Grow Older, Hospitals Begin Requiring Them to Prove They're Still Fit*, Wash.. Post. (Dec. 10, 2012), https://www.washingtonpost.com/national/health-science/as-doctors-grow-older-hospitals-begin-requiring-them-to-prove-theyre-still-fit/2012/12/10/42bb4d90-2d0e-11e2-a99d-5c4203af7b7a_story.html?utm_term=.1706580d8f99; Catherine M. DesRoches et al., *Physicians' Perceptions*,

advocate for the profession to take action so that others outside the profession do not do it for them.⁸

Despite the impetus to do so, healthcare organizations should not institute an age-based cognitive screening program unless certain conditions are satisfied. These conditions are that clear evidence supports the rationale for the program and that the program is not legally prohibited. This Article argues that neither condition is currently met.

Part I of this Article argues that the evidence does not support the need for across-the-board age-based cognitive screening of late-career physicians. Part II argues that such screening is not justified because of screening tool limitations, risk of misdetection and misinterpretation, and insufficient data regarding costs, benefits, harms, and cost-effectiveness of such programs. Part III argues that two federal statutes prohibit age-based screening. Under the Age Discrimination in Employment Act of 1967⁹ (the "ADEA"), such screening is unlawful discrimination because it imposes burdens on older physicians on the basis of age. Under the Americans with Disabilities Act of 1990

Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues, 304 JAMA 187, 191 (2010); Eric G. Campbell et al., *Professionalism in Medicine: Results of a National Survey of Physicians*, 147 ANN. INTERNAL MED. 795, 798 (2007).

8. See COUNCIL ON MED. EDUC., AM. MED. ASS'N, REP.5-A-15: COMPETENCY AND THE AGING PHYSICIAN 12 (2015), available at <https://www.cppph.org/wp-content/uploads/2016/02/AMA-Council-on-Medical-Education-Aging-Physician-Report-2015.pdf>. [hereinafter Report 5] ("Formal guidelines on the timing and content of testing of competence . . . may head off a call for mandatory retirement ages or imposition of guidelines by others."); LoboPrabhu et al., *supra* note 6, at 452 (stating "In the absence of professional initiatives to address the issue of the aging impaired physician, civic, and consumer healthcare organizations concerned with assuring optimal medical care may take the lead").
9. Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621-634 (2006).

and the ADA Amendments Act of 2008 (ADAAA)¹⁰ (collectively, the "ADA"), age-based screening is prohibited discrimination because it constitutes an inquiry and examination without cause and violates the requirements of the "business necessity" exception. This section also argues that even if the hospital does not directly employ the physician, the hospital is the "employer" for purposes of the ADEA and the ADA and must comply with their requirements. Finally, Part IV suggests alternative methodologies for identifying physicians who pose a risk to patient safety. It argues that existing common-law doctrines and private and public regulations provide the incentives, authority, and framework for hospital leaders and medical staff to use non-discriminatory methods and processes to identify impaired physicians, regardless of age. These methodologies and processes align with the principles of the ADEA and the ADA, thereby striking an appropriate balance between promoting patient safety and treating physician employees in a fair, equitable, and legally authorized manner.

I. Age Not a Valid Basis for Imposing Testing on Physicians

Twenty-nine percent (29%) of the one million licensed physicians are sixty or older.¹¹ While not all licensees are engaged in active practice, 111,000 physicians sixty-five or older account for 12 percent of all physicians delivering patient care.¹² Physicians are also retiring later. The mean retirement age was 63.3 in 2005, but by 2014 increased to 67.7 years.¹³ Furthermore, the number

10. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 *et. seq.* and ADA Amendments Act of 2008 (ADAAA), Pub. L. 110-325.

11. See Young *et al.*, *supra* note 2, at 10, 14.

12. AM. MED. ASS'N, *supra* note 1 (*citing* 2013 statistics).

13. ASSOCIATION OF AMERICAN MEDICAL COLLEGES, THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2014 TO 2025: 2016 UPDATE, 35 (2016), available at https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf [hereinafter AAMC]

of actively practicing physicians sixty and older increased 30 percent between 2010 and 2016, while the number of physicians forty-nine or younger increased by only 10 percent.¹⁴

The fact that many physicians continue practicing beyond the traditional retirement age comes at an opportune time because the U.S. faces a physician shortage within the next decade.¹⁵ Estimates of the deficit are that it will reach 61,700 to 94,700 physicians by 2025.¹⁶ However, there are countervailing concerns that older physicians may have deficiencies in the neuropsychological functions required to practice competently. Such functions include verbal problem-solving, visual-spatial problem-solving, learning and memory, verbal fluency, attention, and mental tracking.¹⁷ Because availability and quality of care are both critical public goals, these concerns must be addressed.

If a plausible argument is to be made for screening a specific population for cognitive impairment, the evidence should carefully demonstrate the necessity of such screening. Policymakers and healthcare leaders must base decision-making on accurate information so they may properly balance the benefits, risks, and costs of such a program. Failure to do so does a disservice to the targeted group and shifts attention away from other opportunities to improve quality and safety.¹⁸

Those seeking to screen late-career physicians and devote resources must demonstrate that this group of physicians presents sufficient risk to patient safety to warrant proceeding. It is therefore necessary to examine the evidence

14. See Young et al., *supra* note 2, at 14.

15. *Id.* at 9; see also Atul Grover et al., *The Nation's Physician Workforce and Future Challenges*, 351 AM. J. MED. SCI. 11, 12 (2016).

16. AAMC, *supra* note 13, at V.

17. John Turnbull et al., *Competence and Cognitive Difficulty in Physicians: A Follow-up Study*. 81 ACAD. MED. 915, 916-17 (2006).

18. See Joel M. Kupfer, *The Graying of US Physicians: Implications for Quality and the Future Supply of Physicians*. 315 JAMA 341, 341-42 (2016).

regarding the relationship between physician age and physician performance.

A. *Effects of Aging on Cognitive Function*

Normal aging is typically accompanied by changes in physical and cognitive function. Physical changes include decline in oxygen consumption rates, kidney function, and cardiovascular function.¹⁹ Using the MicroCog Assessment of Cognitive Functioning²⁰ to evaluate cognition with aging, Powell demonstrated that reasoning, visuospatial ability, and memory and reasoning decline before attention and calculation skills.²¹ Mean performance scores for language, visual-spatial recognition, reasoning, and attention show a sharper decline after age 65.²² The magnitude of these changes, however, becomes increasingly variable with each decade. Benton, for example, found that one-third of octogenarians performed as well as a group of younger adults on nine separate cognitive tests.²³ Overall MicroCog scores for a group of seventy-year olds were lower than scores for a group of forty-year olds, but the 60 percent increase in intra-group variability meant that many older individuals performed as well as those who were much younger.²⁴ A review of 185 gerontological studies confirmed that variability continues to increase with age.²⁵

19. DOUGLAS H. POWELL & DEAN K. WHITLA PROFILES IN COGNITIVE AGING 68-69 (1994).

20. *Id.* at 23-27 and 220 (n. 1) (The MicroCog is a computerized set of testing modules developed by D.H Powell, E.F. Kaplan, D.K. Whitla, et al. Subtests examine reaction time, attention, numeric recall, verbal memory, visuospatial facility, reasoning, and mental calculation.).

21. *Id.* at 74.

22. *Id.* at 202.

23. A. L. Benton et al., *Normative Observations on Neuropsychological Test Performances in Old Age*, 3 J CLINICAL PSYCHOLOGY 33, 38 (1981).

24. Powell & Whitla, *supra* note 19, at 13.

25. E.A. Nelson & D. Dannefer. *Age Heterogeneity: Fact or Fiction? The Fate of Diversity in Gerontological Research*, 32 THE GERONTOLOGIST 17, 19 (1992).

Unlike the changes that commonly accompany aging, cognitive impairment represents a spectrum of disability that ranges from mild cognitive impairment ("MCI") to severe dementia.²⁶ Patients with MCI are usually older and have memory complaints but no other functional impairments.²⁷ "Dementia" refers to a group of symptoms caused by permanent damage to the brain's nerve cells²⁸. These symptoms include loss of memory, judgment, language, complex motor skills, and other intellectual functions.²⁹ Alzheimer's accounts for 70 percent of cases, but dementia may also result from vascular events (strokes), Lewy bodies (abnormal proteins in the brain that disrupt neurologic function), alcohol abuse, frontotemporal deterioration, or trauma.³⁰ Prevalence estimates for dementia in the general population vary. One study, for example, estimated 0.8 percent prevalence among 65-69 year olds³¹ with doublings of cases for every successive five-year period.³² Others note an overall 5 percent prevalence

26. See Perminder S. Sachdev et al., *Classifying the Neurocognitive Disorders: the DSM-5 Approach*, 10 *NATURE REV. NEUROLOGY* 634, 641 (2014). (The latest version of the Diagnostic and Statistical Manual of Mental Disorders brings diseases resulting in cognitive impairment under one umbrella called Neurocognitive Disorders, Major and Minor).

27. See Lesley J. Ritchie & Holly Tuokko, *Mild Cognitive Impairment: Case Definitions, Age, and Other Risk Factors*, in *INT'L ENCYCLOPEDIA OF REHAB.* 1 (Stone JH, Blouin M, eds 2013); David G. Le Couteur et al., *Political Drive to Screen for Pre-Dementia: Not Evidence Based and Ignores the Harms of Diagnosis*. 347 *BRIT. MED. J.* 1, 2 (2013).

28. National Institute on Aging, *What Happens to the Brain in Alzheimer's Disease?*, U.S. DEPARTMENT OF HEALTH AND HUMAN RESOURCES, <https://www.nia.nih.gov/health/what-happens-brain-alzheimers-disease> (accessed Dec. 6, 2017).

29. See Sachdev et al., *supra* note 26, at 636.

30. *Id.* at 639; Ron Brookmeyer et al., *National Estimates of the Prevalence of Alzheimer's Disease in the United States*, 7 *ALZHEIMERS DEMENTIA* 61, 69 (2011).

31. Van der Flier, *supra* note 5, at v3.

32. *Id.*; A.F. Jorm & D. Jolley, *The Incidence of Dementia*, 51 *NEUROLOGY* 728, 728 (1998).

among 71-79 year olds.³³ Aging post-World War II "baby boomers" will add to the number of Alzheimer's cases.³⁴

B. Evidence that Late-Career Physicians Function Well

One cannot assume, however, that the prevalence of dementia among working physicians in their sixties and seventies is equal to that in the general population. The reasons why physicians retire are not always known,³⁵ but there is evidence that some depart because they perceive they are practicing less competently than they once did.³⁶ Powell noted that by age seventy-five, non-retired physicians have superior visual-spatial, verbal memory, attention and calculation skills relative to their retired peers.³⁷ He concluded that the most likely explanation was that these physicians were

33. B. L. Plassman et al. *Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study*. 29 *NEUROEPIDEMIOLOGY* 125, 128 (Table 2) (2007); Brookmeyer et al., *supra* note 30, at 69 (Table 3).

34. Alzheimer's Association, *New Analysis Shows More Than 28 Million Baby Boomers Will Develop Alzheimer's Disease; Will Consume Nearly 25% Of Medicare Spending* (Jul 20, 2015). https://www.alz.org/aaic/_downloads/mon-930am-baby-boomers.pdf.

35. Tania Haddad, *Cognitive Assessment in the Practice of Medicine-Dealing with the Aging Physician*, *PHYSICIAN EXECUTIVE J.* 14, 16 (July & Aug. 2013). See also, John Harrison, *Doctors' Health and Fitness to Practise: The Need for a Bespoke Model of Assessment*, 58 *OCCUPATIONAL MED.* 323, 324, 325 (2008) (stating that the most common reasons for early retirement in the U.K. are psychiatric disorders (e.g., depression, bipolar disease), musculoskeletal disorders, and cardiovascular disease).

36. See Linus A. Bieliaskus et al., *Cognitive Changes and Retirement Among Senior Physicians (CCRASS): Results from the CCRASS Study*, 207 *J. AM. C. SURGEONS* 69, 73-75 (2008) (The mismatch between subjective perception of decline and objective measurement on cognitive testing suggests that self-perception of decline may not always be valid, that the testing is not sensitive enough, or that some individuals mistake the typical changes of aging as a threat to their ability to practice at a level they would like.).

37. Powell & Whitla, *supra* note 19, at 202-03.

at the top of the intra-group variability range,³⁸ suggesting that a self-selection process is at work. Another study³⁹ administered computerized cognitive tests to two groups of surgeons, one between 45-59 years of age and the other 60-86 years of age.⁴⁰ The tests evaluated rapid visual information processing, reaction time and psychomotor speed, and visuospatial processing.⁴¹ While the overall performance of the older physician group was below that of the younger physicians, a majority of individuals within the older group fell within the performance range of the younger group.⁴²

Several other studies have also shown that physicians in their sixties and beyond continue to function well and benefit their patients.⁴³ A study sponsored by the American College of Surgery, for example, found that half of practicing surgeons over sixty-five reported no reduction in the complexity of their caseload, and that the majority continue to learn and contribute to new technology.⁴⁴ Many studies also demonstrate that older physicians have favorable clinical outcomes. Reviewing complication and mortality rates for a cohort of 15,000 individuals in Illinois who underwent segmental colon resection, one researcher observed that the most experienced surgeons achieved the lowest mortality rates.⁴⁵ Epstein et al. found that

38. *Id.*; see also Benton et al., *supra* note 23.

39. Lauren L. Drag et al., *Cognitive Functioning, Retirement Status, and Age: Results from the Cognitive Changes and Retirement among Senior Surgeons Study*, 211 J. AM. C. SURGERY 303 (2010).

40. *Id.* at 305 (Table 1).

41. *Id.* at 304.

42. *Id.* at 306.

43. Kupfer, *supra* note 18, at 341-42; Kevin W. Eva, *The Aging Physician: Changes in Cognitive Processing and Their Impact on Medical Practice*, 77 ACAD. MED. S1 (2002).

44. H. Jin Lee et al. *Results from the Cognitive Changes and Retirement among Senior Surgeons Self-Report Study*, J. AM. C. SURG. 668, 669-670 (2009).

45. See Jay B. Prystowsky et al., *Patient Outcomes for Segmental Colon Resection According to Surgeon's Training, Certification, and Experience*, 132 SURGERY 663, 663 (2002).

obstetricians' maternal complication rates continued to decrease over thirty years of medical practice.⁴⁶

Older physicians who maintain a high-volume practice appear to preserve their clinical skills. Waljee et al., for example, found that for the majority of procedures, patient outcomes for surgeons over sixty were comparable to those of younger peers.⁴⁷ The exception was higher mortality rates for three specific complex procedures when performed by surgeons who did these procedures infrequently.⁴⁸ A recent article also demonstrated that the 30-day mortality rate (patient deaths within 30 days of admission) for physicians over sixty who treat a high volume of elderly inpatients is similar to that of younger physicians in the same milieu.⁴⁹ McAlister et al. found no differences in outcomes at seven teaching hospitals irrespective

46. Andrew J. Epstein et al. *Association between Physicians' Experience after Training and Maternal Obstetrical Outcomes: Cohort Study*, 346 *BRIT. MED. J.* 1, 3 ((2013)).

47. Jennifer F. Waljee et al., *Surgeon Age and Operative Mortality in the United States*. 244 *ANNALS SURGERY* 353, 359 (2006).

48. *Id.* at 357. See also, Liam O'Neill, Douglas Lanska, Arthur Hartz, *Surgeon Characteristics Associated with Mortality and Morbidity Following Carotid Endarterectomy*, 55 *NEUROLOGY* 773, 775 (2000) (finding higher 30-day mortality rate for low volume (1-2 procedures per year) surgeons.). But see, Arthur J. Hartz, Evelyn M. Kuhn, Jose Pulido, *Prestige of Training Programs and Experience of Bypass Surgeons as Factors in Adjusted Patient Mortality Rates*, 37 *MED. CARE* 93, 101 (1999). (finding years in practice was associated with higher mortality ratios for coronary bypass procedures after controlling for volume. The authors noted that younger surgeons receive training "in the newer and most effective surgical techniques" but also considered that older physicians' skills may decline.).

49. See Yusuke Tsugawa et al. *Physician Age and Outcomes in Elderly Patients in Hospital in the U.S.: Observational Study*, 357 *BRIT. MED. J.* 1, 5 (2017) (noting also that low volume offers less reinforcement of skills and that, while younger hospitalists receive specialized hospitalist training, older physicians tend to convert a general internal medicine practice into a hospitalist practice. (*Id.* at 7-8). The authors did not suggest cognitive differences caused the findings.).

of physician experience (years in practice ranged from four to fifty-five years⁵⁰), patient volume, diagnosis, or patient complexity.⁵¹

Late-career physicians generally perform well in other ways. Many evolve their practice and assume new roles over time.⁵² BeyondBlue, an Australian study analyzing physicians of all ages, found that those above 60 had the lowest rates of suicidal ideation, anxiety, depression, burnout, and "cynicism."⁵³ Another study noted that physicians between fifty-five and sixty-four were no more likely to have recurrent paid malpractice claims than physicians between forty-five and fifty-four.⁵⁴ The researchers did not analyze claims for those over sixty-four. Other research shows that the over-65 physician population enjoys the lowest medical malpractice claims rate,⁵⁵ as well as the fewest

50. Finlay A. McAlister et al. *Physician Experience and Outcomes Among Patients Admitted to General Internal Medicine Teaching Wards*, 187 CANADIAN MED. J. ASS'N 1041, 1044 (2015).

51. *Id.* at 1045.

52. Carmelle Peisah et al., *Medical Masters: A Pilot Study of Adaptive Ageing in Physicians*, 28 AUSTRALASIAN J. ON AGEING 134, 137 (2009).

53. BEYONDBLUE, NATIONAL MENTAL HEALTH SURVEY OF DOCTORS AND MEDICAL STUDENTS (2013), available at https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web.

54. David M. Studdert et al., *Prevalence and Characteristics of Physicians Prone to Malpractice Claims*, 374 NEW ENG. J. MED. 354, 359 (2016).

55. Mark I. Taragin et al., *Physician Demographics and the Risk of Medical Malpractice*, 93 AM. J MED. 537, 539 (1992) ("A physician's risk of having a claim filed against him/her was greatest between the ages of 36 and 55, peaking around 40.")

unsolicited patient complaints,⁵⁶ a marker for medical malpractice risk.⁵⁷

The availability of newer analytic techniques provides fresh insights into physician performance over the course of their careers. One study used big data—124 quality measures from RAND’s Quality Assessment tools, 10,408 Massachusetts physicians, and claims from 1.13 million adult patients filed with the state’s major commercial health plans—to analyze physician characteristics against quality metrics.⁵⁸ Practice experience ranged from fewer than ten years to more than fifty years.⁵⁹ The results showed no relationship between quality and a physician’s years of experience.⁶⁰ The size of the study population and the inclusion of physicians across a wide age spectrum make the results of this study worth considering because it provides a larger perspective of how well older physicians function in practice.

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56. Cherie A. Fathy et al., *Association Between Ophthalmologist Age and Unsolicited Complaints*, JAMA OPHTHALMOLOGY E1, E3, Nov. 30, 2017 (“The oldest age band (>70 years) had . . . the lowest complaint rate (0.71 complaints per 1000 follow-up days vs 1.41 for age 61 to 70 years, 1.84 for 51 to 60 years, 2.02 for 41 to 50 years, and 1.88 for 31 to 40 years.”).
57. See Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951, 2955 (2002); Ilene N. Moore et al., *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175, 1197–1199 (2006); Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk in a Regional Healthcare Center*, 100 S. MED. J. 791, 794 (2007); see also, Rita K. Cydulka et al. *Association of Patient Satisfaction with Complaints and Risk Management Among Emergency Physicians*, 41 J. EMERGENCY MED. 405, 408 (2011); Osnat Levtzion-Korach et al., *Integrating Incident Data from Five Reporting Systems to Assess Patient Safety: Making Sense of the Elephant*, 36 JOINT COMMISSION J. ON QUAL. & PATIENT SAFETY 402, 408 (2010); and Henry T. Stelfox et al., *The Relation of Patient Satisfaction with Complaints against Physicians and Malpractice Lawsuits*, 118 AM. J. MED. 1126, 1131 (2005).
58. Rachel L. Orler et al., *Associations Between Physician Characteristics and Quality of Care*, 170 ARCHIVES INTERNAL MED. 1442, 1443–45 (2010).
59. See *id.*
60. See *id.* at 1445.

C. *Limitations of Studies Cited as Evidence of the
Need for Age-Based Testing*

Many of the studies that age-based screening advocates cite to support their position are not relevant to their argument or are misapplied. Studies and commentators sometimes conflate concepts, misstate information, offer little data specific to the demographic of interest, or ignore other non-age-related physician characteristics associated with performance and cognition issues.

1. Concept Conflation

Most studies about physician dyscompetency or performance do not involve cognitive evaluation. Dyscompetency and cognitive impairment are different constructs, although some individuals manifest both.⁶¹ Dyscompetency, “a failure to maintain acceptable standards in one or more areas of professional practice,” may be due to lack of training or failure to stay current with standards of practice.⁶² Impairment, on the other hand, is “the inability of a physician to practice medicine with reasonable skill and safety by virtue of a mental or physical illness or excessive use or abuse of a controlled substance, alcohol, or other substances that impair ability.”⁶³ By conflating the concepts of dyscompetency and cognitive impairment, those who support age-based cognitive screening claim a larger literature than actually exists.

Concept conflation can also lead to propagation of errors easily missed unless the reader consults the original source. A case in point is Wilson et al.’s study of harm-causing medical “adverse events” (“AEs”), which found that “cognitive

61. See, e.g., John Turnbull et al., *Cognitive Difficulty in Physicians*, 75 *ACAD. MED.* 177, 180 (2000) [hereinafter Turnbull, 2000]; Neha Kataria et al., *A Retrospective Study of Cognitive Function in Doctors and Dentists with Suspected Performance Problems: An Unsuspected but Significant Concern*, 5 *ROYAL SOC’Y MED.* 1,3 (2016).

62. Betsy W. Williams, *The Prevalence and Special Educational Requirements of Dyscompetent Physicians*, 26 *J. CONTINUING EDUC. HEALTH PROFESSIONS* 173, 174 (2006).

63. *Id.*

failure . . . appears to have a role in 57% of all the causes of AEs.”⁶⁴ In the paper, the authors cited Leape⁶⁵ who writes about the ubiquitous problem of error in medicine, and healthcare professionals’ vulnerabilities to making “errors of cognition.”⁶⁶ Several authors later cited Wilson et al. and transformed the term “cognitive failure”—synonymous with Leape’s “errors of cognition”—into “cognitive impairment.”⁶⁷ A misstatement that 57 percent of adverse events are caused by cognitive impairment is not only untrue, but it has the potential to lead readers to believe that neurocognitive disorders account for the majority of cases of harm-causing medical error in the United States.⁶⁸ Perry and Crean are among those who misquoted Wilson, but in their case additionally inflated the statistic, from 57

64. Ross McL Wilson et al., *An Analysis of the Causes of Adverse Events from The Quality in Australian Health Care Study*, 170 *MED. J. AUSTRAL.* 411 (1999).

65. *Id.*

66. Lucian L. Leape, *Error in Medicine*, 272 *JAMA* 1851, 1852 (1994) (“All humans err frequently.” Leape encourages conscious “error proofing” of the medical care environment to help address the cultural and psychological human factors that lead to ongoing medical error.). See generally, JAMES REASON, *HUMAN ERROR* (1st ed. 1990); Pat Crosskerry, *The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them*, 78 *ACAD. MED.* 775, 777 (2003) (categorizing 32 types of cognitive error that lead to diagnostic error); Saul N. Weingart et al. *Epidemiology of Medical Error*, 320 *BRIT. MED. J.* 774, 791 (2000) (noting that clinicians who are inexperienced or undertake new techniques are prone to error).

67. See e.g., Mervi Pitkanen et al., *Doctor’s Health and Fitness to Practice: Performance Problems in Doctors and Cognitive Impairments*, 58 *OCCUPATIONAL MED.* 328, 328 (2008); Kataria et al., *supra* note 61, at 1; Betsy W. Williams et al., *Assessment of Fitness for Duty of Underperforming Physicians: The Importance of Using Appropriate Norms*, 12 *PLOS ONE* 1, 2 (2017) [.

68. See Institute of Medicine, *To Err Is Human: Building a Safer Health System*, *NAT’L ACAD. PRESS* (2000) (estimating that 98,000 deaths are caused each year in the United States by medical error).

percent to 63 percent,⁶⁹ as did Pitkanen et al.⁷⁰ It is unclear whether conflating terms contributes to the push to test older physicians, but these examples illustrate how misstatements at best create confusion and at worst, a false perception of an urgent need to “do something” about these “dangerous doctors.”

The conflation of dyscompetency and impairment concepts additionally disadvantages older physicians by suggesting that they should no longer practice if identified as dyscompetent. Eva⁷¹ points out that when an older physician is dyscompetent, the primary indicators are out-of-date medical knowledge and a decline in data-gathering and analytic confirmation strategies.⁷² This does not mean, however, that the physician is incompetent to practice medicine.⁷³ Older physicians have superior non-analytic skills by which they use their experience to generate diagnoses based on contextual information.⁷⁴ Less use of analytic strategies, however, may at times result in premature closure⁷⁵—finalizing a diagnosis before fully verifying⁷⁶—and misdiagnosis. Eva shares the insight that some of the negativity about older physicians likely derives from a belief they cannot change.⁷⁷ Yet, he notes,

69. William Perry & Rebecca D. Crean, *A Retrospective Review of the Neuropsychological Test Performance of Physicians Referred for Medical Infractions*, 20 ARCHIVES CLINICAL NEUROPSYCHOLOGY 161, 162 (2005).

70. Pitkanen et al., *supra* note 67, at 328.

71. Eva, *supra* note 43, at S1.

72. *Id.* at S2.

73. *Id.* at S4.

74. *Id.*

75. *Id.* See also, Leape, *supra* note 66, at 1853 (discussing “biased memory” as one cause of medical error. “Decisions are based on what is in our memory, but memory is biased toward overgeneralization and overregularization of the commonplace. Familiar patterns are assumed to have universal applicability because they usually work. We see what we know.”).

76. See, Crosskerry, *supra* note 66, at 778; AHRQ, U.S., Dept of Health and Human Services, *Diagnostic Errors* (June 2017).

77. Eva, *supra* note 43, at S2.

specific education can remediate and strengthen analytic skills.⁷⁸ Turnbull, too, points out that both older and younger dyscompetent physicians are able to successfully remediate provided the absence of neurocognitive impairment.⁷⁹

Schenarts and Cemaj's article about the aging surgeon⁸⁰ conflates data and juxtaposes text in a way that also tends to create misimpression about older physicians. In a section entitled "Psychiatric Illness," they discuss "mental and psychiatric disease . . . in the elderly physician."⁸¹ After listing various conditions that can cause impairment,⁸² they include the BeyondBlue⁸³ study's finding that: "[N]early 10% of surgeons reported having suicidal ideation in the previous year. In the same study 2.5% of surgeons had serious psychological distress, and 20.5% had a high likelihood of a minor psychiatric disorder."⁸⁴ The juxtaposition suggests that these data refer to older physicians, the subject of their article. In fact, the authors mis-cite the BeyondBlue study. The BeyondBlue data they include are for all surgeons. BeyondBlue also published data specific to physicians over sixty, which the authors do not mention. The respective corresponding percentages for these older physicians – 6%,⁸⁵ 0.9%,⁸⁶ and 12.8%.⁸⁷ – were far lower than for all surgeons.

The concern is that studies that conflate concepts and propagate erroneous statistics may create faulty perceptions that then underlie questionable policies. The California Public

78. *Id.* at 55.

79. Turnbull et al., *supra* note 17, at 918.

80. Paul J. Schenarts & Samuel Cemaj, *The Aging Surgeon: Implications for the Workforce, the Surgeon, and the Patient*, 96 *SURGICAL CLINICS N. AM.* 129, 129 (2016).

81. *Id.* at 133.

82. *Id.*

83. BeyondBlue, *supra* note 53.

84. Schenarts & Cemaj, *supra* note 80, at 133.

85. BeyondBlue, *supra* note 53, at 33 (Table 16).

86. *Id.* at 23 (Table 9).

87. *Id.* at 21 (Table 8).

Protection and Physician Health, Inc. ("CPPPH")⁸⁸ has already issued guidelines for healthcare organizations considering age-based screening. These guidelines recommend a comprehensive assessment of older physicians that includes a cognitive screen.⁸⁹ They present "the clinical case for assessing late-career practitioners"⁹⁰ in a brief discussion and refer to an additional short reference list of articles, written largely by commentators.⁹¹ The brief discussion cites the Pitkanen article⁹² for its reference to the Perry and Crean study.⁹³ CPPPH's indirect inclusion of this reference to support age-based policies is problematic, because while the study found neuropsychological deficits among physicians with performance issues,⁹⁴ there were no analyses that suggested a special concern with late-career physicians.⁹⁵ CPPPH also cites the previously mentioned study by Waljee et al.,⁹⁶ stating that older surgeons had higher mortality rates for some complex procedures.⁹⁷ CPPPH does not mention the favorable outcomes for high volume surgeons comparable to younger colleagues', nor does it

88. California Public Protection and Physician Health, Inc., *Assessing Late Career Practitioners: Policies and Procedures for Age-Based Screening*, (April 2015), <http://www.cppph.org/cppph/wp-content/uploads/2015/07/assessing-late-career-practitioners-adopted-by-cppph-changes-6-10-151.pdf> [hereinafter CPPPH].

89. *Id.* at 8. ("physical examination, assessments from peers and co-workers, and assessment of cognitive function.")

90. *Id.* at 5-6.

91. CPPPH, *supra* note 88, at 33.

92. *Id.* at 5-6.

93. Perry & Crean, *supra* note 69.

94. *Id.* at 168.

95. Authors expressly cautioned against drawing definitive conclusions from his study because subjects were not compared to a non-referred, age-matched comparison group. *Id.* at 167-68.

96. See generally, Waljee et al., *supra* note 47.

97. CPPPH, *supra* note 88, at 5.

include the authors' conclusion that "surgeon age is not an important predictor of operative risk."⁹⁸

CPPPH lists the California Medical Association and California Hospital Association's Center for Healthcare Medical Executives as contributors to the guidelines.⁹⁹ The imprimatur of these influential organizations implies they endorse the guidelines' findings. The American Medical Association ("AMA")'s Council on Medical Education's "Competency and the Aging Physician" report, in turn, referenced the CPPPH guidelines.¹⁰⁰ The AMA report noted that the guidelines offer "options for assessing physicians who choose to work late into their careers."¹⁰¹ The report ultimately concluded that there was "a need to . . . establish guidelines for . . . testing . . . aging/late career physicians' competence to care for patients."¹⁰²

2. Lack of Age Stratification

Much of the research cited in support of age-based screening programs fails to elucidate specific information about the late-career physicians who would be the target of such programs. To begin with, the studies generally do not stratify findings sufficiently to distinguish between mid- and late-career physicians.¹⁰³ Other studies focus on unique

98. See, Waljee et al, *supra* note 47, at 360.

99. CPPPH, *supra* note 88, at 4.

100. Report 5, *supra* note 8, at 6.

101. *Id.*

102. *Id.* at 1. The AMA report articulated two Directive[s] to Take Action: The first was to "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. The second was to "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 . . . serve as the basis for guidelines more grounded in research findings." *Id.* at 13.

103. See, e.g., William N. Southern et al., *Longer Lengths of Stay and Higher Risk of Mortality among Inpatients of Physicians with More Years of Practice*, 124 AM. J. MED. 868, 873 (Table 1) (2011) (no stratification of group

populations of physicians referred by licensing authorities or hospitals to remediation/assessment centers¹⁰⁴ for concerns about competency¹⁰⁵ or negligence¹⁰⁶. Many of the studies also have design limitations, such as small sample size, non-random sampling, or lack of controls, which may limit generalizability of the findings.¹⁰⁷ Extrapolating conclusions from such studies to the physician community-at-large therefore requires great caution.¹⁰⁸

Choudhry et al.'s¹⁰⁹ oft-cited¹¹⁰ meta-analysis of sixty-two studies evaluated various quality of care

with >20 years of practice); J. Sanford Schwartz et al., *Internists' Practices in Health Promotion and Disease Promotion*, 114 ANNALS INTERNAL MED. 46 (1991) (oldest study group is >/=56 years old).

104. See, e.g., Alma Saravia, *Determining Whether a Physician is Competent to Practice Medicine is Complex*, MD (Sept 8, 2017), <http://www.mdmag.com/physicians-money-digest/lifestyle/determining-whether-a-physician-is-competent-to-practice-medicine-is-complex>; LoboPrabhu et al., *supra* note 6, at 448. For a list of programs, including many to which state medical boards refer, see Federation of State Medical Boards, *Directory of Physician Assessment and Remedial Education Programs*, <http://www.fsmb.org/globalassets/usmle-step3/spexplaspdfs/remedprog.pdf>.
105. See Geoffrey R. Norman et al., *Competency Assessment of Primary Care Physicians as Part of a Peer Review Program*, 270 JAMA 1046, 1048-49 (1993).
106. See, e.g., Perry & Crean, *supra* note 69, at 163.
107. See Kupfer, *supra* note 18, at 341 ("[S]tudies linking physician age, cognitive function, and clinical performance have been limited by small sample size and use of historical case-control groups, were conducted among physicians selected because of poor clinical performance, and lacked a well-defined normative group. As a result, cognitive screening may not be applicable to all groups of aging physicians.").
108. *Id.*
109. Niteesh K. Choudhry et al., *Systematic Review: The Relationship between Clinical Experience and Quality of Healthcare*, 142 ANNALS INTERNAL MED. 260 (2005).
110. See, e.g., Ralph B. Blasier, *The Problem of the Aging Surgeon: When Surgeon Age Becomes A Surgical Risk Factor*, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 402, 404 (2009); Haddad, *supra* note 36, at 16; Bieliaskus et al., *supra* note 36, at 69; Elizabeth S. Grace et al.,

measures such as compliance with evidence-based guidelines and medical knowledge. The study, however, did not address cognitive impairment. The researchers concluded that thirty-two of the studies (52 percent) showed an inverse relationship between "performance" and age or years in practice.¹¹¹ However, many of the studies with a negative age association grouped their cohorts in brackets such as ">10 years" or ">20 years in practice,"¹¹² which would include physicians in their forties and fifties, respectively, or used an age between forty and fifty to divide physicians into two large groups.¹¹³ The age range of these cohort groups is too wide to justify screening for a particular narrow subset. Furthermore, as the article points out, several of the included studies did not present statistical tests.¹¹⁴

Multiple other studies offered as support for the need for age-based screening are also not persuasive. Caulford et al.,¹¹⁵ for example, claimed

Predictors of Physician Performance on Competence Assessment: Findings from CPEP, the Center for Personalized Education for Physicians, 89 ACAD. MED. 912, 917 (2014); Christine Y. Moutier et al., *Approaching the Issue of the Aging Physician Population*, 99 J. MATERIALS RES. 10, 11 (2013). See also Steven E. Weinberger et al., "Practice Makes Perfect" . . . Or Does It?, 142 ANNALS INTERNAL MED. 302 (2005) (the accompanying editorial to Choudhry et al.'s article, stating that the study highlights the need for physicians to stay current with changes in medicine).

111. Choudhry et al., *supra* note 109, at 261. The Article's conclusions are also sometimes misstated. See, e.g., Chanaka Wijeratne & Carmelle Peisah, *Accepting the Challenges of Ageing And Retirement In Ourselves: The Need for Psychiatrists to Adopt a Consensus Approach*, 47 AUSTRALIAN & NEW ZEALAND J. PSYCHIATRY 425, 426 (2013) (incorrectly citing Choudhry et al.'s finding that "52%" of the studies reviewed showed an inverse relationship between age and performance as "73%".).

112. See Choudhry et al., *supra* note 109, at 266-68.

113. See *id.* at 264-68.

114. See *id.* at 264.

115. Paul G. Caulford et al., *Physician Incompetence: Specific Problems and Predictors*, 69 ACAD. MED. 516 (1994).

age was associated with dyscompetency¹¹⁶ but did not include any detail about the subjects' ages or age range. Turnbull et al.'s 2000 study found seven of twenty-seven physicians in Ontario's Physician Review Program ("PREP") to have cognitive impairment.¹¹⁷ Of these, three were under sixty (ages forty-seven, forty-eight, and fifty-two), and four were sixty or above (ages sixty, sixty-one, sixty-four, and sixty-five).¹¹⁸ In their 2006 study of forty-five PREP physicians referred for competency concerns, twelve physicians had evidence of cognitive impairment on an age-adjusted analysis, which increased to seventeen on an age-independent analysis.¹¹⁹ The authors specified 35-40 as the age range of the reference group for the age-independent analysis but did not state the age range or age distribution of the study cohort.¹²⁰ Kataria et al.'s review of 109 physicians and dentists referred to the United Kingdom's National Clinical Assessment Service for performance issues¹²¹ identified fourteen (13 percent) with cognitive impairment.¹²² Of these, the two youngest were in their forties, one was over seventy, and the authors did not discuss the age distribution of the remaining eleven.¹²³

A larger study at the Colorado Personalized Education for Physicians ("CPEP") program¹²⁴ evaluated 683 physicians referred for evaluation by their state medical board or hospital. All underwent a cognitive screen, structured clinical interviews, simulated patient encounters, written tests, and

116.*Id.* at 518.

117.Turnbull, 2000, *supra* note 61, at 178.

118.*Id.* at 179 (Table 1 contains a formatting error that was later corrected. The revised Table 1 is available from the corresponding author. See, Turnbull et al., *supra* note 17, at 915. The list of impaired subjects' ages is based on the revised Table.).

119.Turnbull et al., *supra* note 17, at 916.

120.*Id.* at 916-17 (Table 2).

121.See Kataria et al., *supra* note 61, at 1-2.

122.*Id.* at 4 (Table 4).

123.*Id.* at 4-5.

124.Grace et al., *supra* note 110.

chart reviews.¹²⁵ The study found 12.6 percent of the referred physicians unsafe to practice, requiring remediation in a residency program.¹²⁶ The authors provided the average age (53.1) and age range (32-84) of the 683 physicians without further stratification,¹²⁷ except that the average age of the "unsafe" group was 5.1 years older than the group deemed safe to practice.¹²⁸ Interestingly, the authors did not include any results related to the cognitive screenings they performed.

Norman et al.¹²⁹ reported on the first three years (1989-1992) of the PREP program. The researchers described how the College of Physician and Surgeons of Ontario ("CPSO"), the provincial licensing body, selected 450 of the province's 17,000 physicians for peer review assessment.¹³⁰ All physicians seventy years old or older received an assessment, but CPSO randomly selected the participants that were under age seventy. The study did not mention how many of the 450 physicians evaluated were seventy or older. Out of the 450, thirty-seven physicians underwent clinical competency testing due to either persistent patient care or record-keeping deficiencies or because they were under CPSO discipline.¹³¹ Researchers compared the performance of this group with a non-age-matched younger reference group, leading to a not surprising difference in the mean age of the groups: 52.4 (SD+/-14.1) vs. 46.6 (SD+/-11.5).¹³² The authors offered no further

125. *Id.* at 913.

126. *Id.* at 916.

127. *Id.* at 914.

128. *Id.* at 916.

129. Norman et al., *supra* note 105, at 1047.

130. *Id.*

131. *Id.*

132. *Id.* at 1048. Assuming a normal distribution, 68% of the referral group was between the ages of 38 and 66, with another 16% younger than 38, and 16% who were older than 66. For detailed discussions of the normal distribution, see DOUGLAS G. ALTMAN, PRACTICAL STATISTICS FOR MEDICAL RESEARCH 54-57 (1999); Andy Kierz, *Here's What Nerds Mean When They Say 'Standard Deviation'*, BUSINESS INSIDER (Dec 2, 2014), <http://www.businessinsider.com/standard-deviation-2014-12> (explaining that a standard deviation,

stratification of performance and age. Because older physicians were intentionally oversampled, the reference group was not age-matched, and the broad standard deviation suggests a wide age range of dyscompetent physicians, the study cannot demonstrate that late-career physicians are disproportionately responsible for dyscompetent practice.

McAuley et al. studied 918 physicians who also received assessments by CPSO.¹³³ The initial selection of physicians was random, but after the first two years, the program selected more physicians from the "older groups."¹³⁴ The physicians underwent review of randomly selected medical charts and an interview.¹³⁵ The researchers found the following distribution of physicians with "grossly deficient records or unsatisfactory level of patient care or both": 35 percent of physicians over the age of seventy-five, 16 percent of physicians between fifty and seventy-four; and 9 percent of physicians under age fifty.¹³⁶ The study does raise concern about physicians over the age of seventy-five. However, the middle group with an age range of 50-74 provides insufficient stratification to know if late-career physicians younger than seventy-five evidence more problematic care than mid-career physicians. Furthermore, from a policy standpoint, a 9 percent dyscompetency rate for the under-50 year old physician population suggests that such challenges apply to all physician age groups¹³⁷ and

or SD, is "a measure of how spread out a data set is68% of measurements of a normally distributed quantity should fall within one standard deviation of the mean, 95% of measurements within two standard deviations of the mean, and 99.7% within three standard deviations of the mean.").

133. Ronald G. McAuley et al., *Five-Year Results of the Peer Assessment Program of the College of Physicians and Surgeons of Ontario*, 43 CANADIAN MED. ASS'N J. 1193, 1193-94 (1990).

134. *Id.* at 1195.

135. *Id.* at 1195.

136. *Id.* at 1196 (Table 3).

137. While there is no guarantee that the dyscompetency rates in Ontario correlate to those in the U.S., assuming they do suggests interesting results. The Federation of State

that a sole focus on late-career physicians is misguided. The study did not report cognitive status of the subjects, nor did it discuss reasons why dyscompetency would occur in more recently trained physicians.

3. Non-Age-Related Sources of Impairment

The impetus for age-based cognitive screening without demonstration of a convincing need stands in contrast to how little is said about well-documented non-age-related factors associated with dyscompetency and impairment. Solo practice¹³⁸ and lack of board certification,¹³⁹ for example, are repeatedly identified as associated physician characteristics. In addition, a myriad of medical conditions affect physicians of all ages and could threaten patient safety. Specifically, researchers estimate physician impairment prevalence rates of up to 15 percent due to psychiatric illness, physical illness, alcoholism, and/or drug abuse.¹⁴⁰

Medical Board's 2016 census (see Young, *supra* note 2, at 11) divides U.S. physicians by decades. Using Ontario dyscompetency rates, if distribution groups are shifted to <50, 50-69, and 70+, results should favor the middle group and disfavor the oldest group. The exercise reveals the following: For the youngest group (n=415,234 (49% of total licensed U.S. physicians)), a 9% rate yields 37,371 dyscompetent physicians. For the middle group (n=354,356 (42% of total)), a 16% rate yields 56,697. For the oldest group (n=75,627 (9% of total)), a 35% rate yields 26,469. However, the absolute number in the oldest group would be lower because many no longer practice. Such estimates are relevant to determining how best to identify and address all risks to patient safety.

138. See, e.g., Grace et al., *supra* note 110, at 915; Norman et al., *supra* note 105, at 1049; McAuley et al., *supra* note 133, at 1196 (Table 3). See also Elizabeth F. Wenghofer et al., *Factors Affecting Physician Performance: Implications for Performance Improvement and Governance*, 5 HEALTHCARE POL'Y 141, 151-52 (2009) (noting that insufficient organizational structures and systems likely contribute to the higher prevalence of dyscompetence among solo practitioners, especially in rural practices).

139. See, e.g., Grace et al., *supra* note 110; Caulford et al., *supra* note 115, at S18. McAuley, *supra* note 133, at 1196.

140. See, e.g., Eugene V. Boisubin & Ruth E. Levine, *Identifying and Assisting the Impaired Physician*, 322

Adler and Constantinou report that the Medical Practitioners Board of Victoria (Australia) receives referrals for 1 percent of physicians from every age group.¹⁴¹ Older physicians account for a higher proportion of referrals for cognitive or other health concerns, while younger physician referrals are more often for substance abuse and psychiatric disorders.¹⁴² However, the authors also note that health and cognitive impairment concerns make up 50 percent of all referrals.¹⁴³ Because only 15.7 percent of Victoria's physicians are sixty or older, it appears that a significant number of these latter types of concerns must involve younger physicians.¹⁴⁴

Alcohol and drug abuse remains a significant issue. Seven percent (7%) of physicians will struggle with alcoholism,¹⁴⁵ and 18 percent abuse alcohol or drugs during their lifetime.¹⁴⁶ Chronic alcohol use can cause cognitive dysfunction.¹⁴⁷ Even medical students and residents, the newest members of the profession, are at risk for psychiatric or substance abuse issues that can be difficult to

AM. J. MED. SCI. (2001) 31, 32 (noting estimated drug and alcohol abuse prevalence rates among physicians of 2-14%); Steven L. Dubovsky et al., *Do Data Obtained from Admissions Interviews and Resident Evaluations Predict Later Personal and Practice Problems?*, 29 ACAD. PSYCHIATRY 443, 443 (2005) (estimating an 8-15% prevalence rate of impairing illnesses among physicians); Laetitia L. Thompson, *Neuropsychological Assessment of Physicians Whose Competency to Practice Medicine is Being Questioned*, 373, 374, in CLINICAL NEUROPSYCHOLOGY AND COST OUTCOME RESEARCH: A BEGINNING (George P. Prigatano & Neil H. Pliskin, eds., 2003) (noting that physical and mental conditions impair 7-10% of physicians).

141. Robert G. Adler & Conn Constantinou, *Knowing-or Not Knowing-When to Stop: Cognitive Decline in Ageing Doctor*, 189 MED. J. AUSTRAL. 622, 623 (2008).

142. *Id.* at 623.

143. *Id.*

144. *Id.*

145. Thompson, *supra* note 140, at 375; B. Williams, *supra* note 62, at 186.

146. Boisubain & Levine, *supra* note 140, at 32.

147. B. Williams, *supra* note 62, at 183.

identify through admissions interviews, performance, or faculty evaluations.¹⁴⁸ In one report, department chairs, residency program directors and chief residents believed that emotional problems impaired 12 percent of their residents.¹⁴⁹ In another study, program directors suspected that 1 percent of their residents were alcohol dependent; however, 12 percent of the residents provided answers to CAGE¹⁵⁰ questions that met criteria for diagnosis or suspicion for alcoholism.¹⁵¹

Alcohol and drug abuse is also commonly involved in medical board discipline.¹⁵² In one study, 42 percent of offenses in discipline cases involved impairment, abuse, inappropriate prescribing, possession, and/or other drug-related charge.¹⁵³

148. Dubovsky et al., *supra* note 140, at 443.

149. *Id.*

150. Charles P. O'Brien, *The CAGE Questionnaire for Detection of Alcoholism A Remarkably Useful but Simple Tool*, 300 JAMA 2054, 2054 (2008). (The CAGE screen asks four questions: Have you ever felt you needed to Cut down on your drinking? Have people Annoyed you by criticizing your drinking? Have you ever felt Guilty about drinking? Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover?).

151. Robert M. McNamara & Jeffrey L. Margulies, *Chemical Dependency in Emergency Medicine Residency Programs: Perspective of the Program Directors*, 23 ANNALS EMERGENCY MED. 1072, 1074 (1994); Rebecca S. Feinberg, *The Impaired Physician: Medical, Legal, and Ethical Analysis with a Policy Recommendation*, 34 NOVA L. REV. 595, 627 (2010) ("the majority of physician impairment starts during medical school").

152. See Steven W. Clay & Robert R. Conatser, *Characteristics of Physicians Disciplined by the State Medical Board of Ohio*, 103 J. AM. OSTEOPATHIC ASS'N 81, 85 (Table 3) (2003) (finding that drug and alcohol abuse was the most common reason for discipline in Ohio (21%) and the third most common reason in California); Mark P. McGovern et al., *Characteristics of Physicians Presenting for Assessment at a Behavioral Health Center*, 19 J. ADDICTIVE DISEASES 59, 64 (2000) (noting that referrals originate from medical societies, hospitals/partners, and licensing authorities).

153. Clay & Conatser, *supra* note 152, at 85.

Compared to non-disciplined control groups,¹⁵⁴ these disciplined physicians were more likely to be male,¹⁵⁵ in practice for less than twenty years,¹⁵⁶ and not board-certified.¹⁵⁷

Failure to recognize non-age-related sources of dyscompetency and impairment obscures the need to monitor and intervene with younger members of the profession. In one assessment site, 108 physicians with a mean age of forty-six¹⁵⁸ (the youngest participants were "<35" and the oldest ">55"¹⁵⁹) typically had at least five years of substance abuse with "disruptions in emotional, work, and relationship functioning" prior to their referral.¹⁶⁰ Yet it appears that those who worked most closely with these physicians either failed to identify or failed to act despite ongoing interaction, for only 20 percent of referrals to the assessment program came directly from the physicians' hospitals and practice partners.¹⁶¹

Thus, if a program is to identify at-risk physicians, it must look beyond the single demographic of late-career physicians in light of evidence that most late-career physicians practice safely, and that in all physician age groups there are colleagues who need intervention.¹⁶² The point is not, however, to implement screenings on more physicians, but rather to consider methodologies

154.*Id.* at 82 (stating that one control group was matched for location only and the other control group was matched for location, practice type, specialty, and gender.).

155.*Id.* at 83.

156.*Id.*

157.*Id.*

158.McGovern et. al., *supra* note 152, at 62.

159.*Id.* at 63 (Table 1).

160.*Id.* at 69.

161.*Id.* at 64.

162.Kupfer, *supra* note 18, at 341-42. ("Taking physician age as the sole criterion for assessment could well limit how significantly competency assessment programs can improve patient safety and quality.").

that can monitor for and detect performance issues across the entirety of a physician's career.¹⁶³

II. Justifying the Burdens and Costs of Age-Based Cognitive Screening

In addition to the lack of evidence to justify cognitive screening of every physician above a certain age, any strategy that wastes resources and results in unacceptable levels of misdetection would be of concern.¹⁶⁴ The severity of excessive scrutiny and misdetection would depend on the screening mechanisms used. While less obtrusive and more accurate screening mechanisms may diminish excessive burdens and false positives, they do not eliminate the problem.¹⁶⁵ Furthermore, false negative results among the screened group¹⁶⁶ and the failure to detect significant dysfunctionality among physicians not targeted for increased scrutiny—those who are younger than the age cut-off for screening—are of equal concern because they result in less safe patient care.

For these reasons, it is important to examine any age-based screening program for anticipated costs, potential benefits and harms,¹⁶⁷ and cost-effectiveness.¹⁶⁸ In particular, those who advocate for screening must have sufficient understanding of

163. See *infra* Part IV.

164. See David A. Grimes & Kenneth F. Schulz, *Uses and Abuses of Screening Tests*, 359 *THE LANCET* 881 (2002).

165. Developing Microcog norms that result in higher sensitivity for identifying physicians with cognitive challenges are also less specific and likely to create more false positives. Individuals with false positives would need to undergo extensive further testing to differentiate false from true. See Williams et al., *Assessment of Fitness*, *supra* note 67, at 10.

166. *Id.* at 9.

167. See Grimes & Schulz, *supra* note 164, at 881-82.

168. See Le Couteur, *supra* note 27, at 1; Grimes & Schulz, *supra* note 164, at 882; James M. G. Wilson & Guntner Jungner, *The Principles and Practice of Screening for Disease*, GENEVA: WORLD HEALTH ORG. (1968) (the Wilson and Jungner criteria for screening programs are considered the "gold standard.").

the limitations of the testing methods.¹⁶⁹ Currently, there is a lack of consensus on a screening instrument validated for physicians.¹⁷⁰ Cognitive testing tools are not normed for highly educated individuals like physicians¹⁷¹ who tend to have higher baselines and perform significantly better than their age peers in the general population.¹⁷² Furthermore, the demonstrated value of neuropsychological testing is in settings where the clinician already suspects the patient is

169. See Grimes & Schulz, *supra* note 164, at 882-83.

170. See Dorene M. Rentz et al., *Use of IQ-Adjusted Norms to Predict Progressive Cognitive Decline in Highly Intelligent Older Individuals*, 18 *NEUROBIOLOGY* 38, 45 (2004) (showing IQ-adjusted norms may be a better estimate of decline than norms for age and education). But see, Page, *supra* note 3 ("Doris Gundersen, MD . . . president of the Federation of State Physician Health Programs and medical director of the Colorado physician health program, agrees that 'no cognitive screening tests that I'm aware of have been validated specifically for the physician population . . .'").

171. See Thompson, *supra* note 140, at 385; B. Williams et al., *supra* note 67, at 6 ("[T]he Norm sample for the Microcog does not effectively represent the pilots or the physician samples."); Laurel Sample et al., *Comparing Patient-Management Skills of Referred Physicians and Non-Referred Physicians on a Computer-Based Case-Simulation Examination*, 76 *ACAD. MED.* 524, 524-25 (2001).

172. See Powell, *supra*, note 19, at 71 (" . . . in the two decades after 60, the Normal women and men scored in about the same range as physicians ten years older."); Jennifer S. Lin et al., *Screening for Cognitive Impairment in Older Adults: A Systematic Review for the U.S. Preventative Services Task Force*, *ANNALS INTERNAL MED.* 601, 604 (Nov. 5, 2013) (discussing findings from meta-analysis of studies related to cognitive screening: when education was reported, subjects "usually had at least some high school education;" most screening instruments were involved in only one study; 9 instruments subjected to more than one study showed "limited reproducibility in primary care-relevant populations and unknown optimum cut points for each instrument;" and the six instruments involved in more than one study showed lower sensitivity for diagnosing MCI than dementia.).

cognitively impaired and needs more information,¹⁷³ is assessing the functional status of a patient already diagnosed with cognitive impairment,¹⁷⁴ and is helping with future planning.¹⁷⁵ Thus, as physician normative data are developed,¹⁷⁶ a more appropriate role would be to test physicians, regardless of age,¹⁷⁷ where there is evidence, such as underperformance, to support the need rather than to test physicians who do not demonstrate difficulties.¹⁷⁸

Another challenge with cognitive screening is that healthcare organizations would have difficulty knowing what to do with the information. Not only is it unclear how quality of care and patient outcomes correlate to testing results,¹⁷⁹ there is also no consensus on how to determine what level of impairment is sufficient to warrant removal from practice.¹⁸⁰ Because mean scores continue to decline

173. Latha Velayudhan et al., *Review of Brief Cognitive Tests for Patients with Suspected Dementia.*, 26 INT'L PSYCHOGERIATRICS 1247, 1256-57 (2014).

174. See Thompson, *supra* note 140, at 379-80.

175. Kathleen A. Welsh-Bohmer et al., *The Clinical Utility of Neuropsychological Evaluation of Patients with Known or Suspected Dementia*, in CLINICAL NEUROPSYCHOLOGY AND COST OUTCOME RESEARCH: A BEGINNING 177, 182 (George P. Prigatano & Neil H. Pliskin, eds., 2003).

176. B. Williams et al., *supra* note 67, at 8 (authors estimate that 90% of physicians with cognitive dysfunction may be missed by the MicroCog using general population norms).

177. *Id.* The authors discuss the case of a 54-year-old physician who was experiencing difficulties with behavior and interpersonal communication. Using experimental norms based on meta-analysis of two small physician samples, they identified neurocognitive abnormalities in this physician missed by the general MicroCog norms. The authors also emphasize that their meta-analysis may not apply to a "true population sample of physicians" (*Id.* at 9.), and more data are needed (*Id.* at 10).

178. *Id.* at 2.

179. See Blasier, *supra* note 110, at 405 (stating that "there has not been any showing that a good score on the MicroCog correlates with good performance of surgery or that a low score on the MicroCog correlates with incompetency or lack of skill.").

180. Adler & Constantinou, *supra* note 141, at 623.

after age fifty,¹⁸¹ screening creates risk that organizations might take action on physicians with declining scores even with satisfactory clinical performance.

Some of the information necessary to determine the potential usefulness and economic and non-economic costs of a cognitive screening program is not yet known. This information includes the prevalence of the screened-for condition within the physician population,¹⁸² anticipated frequency of testing, number of screenings required to yield one positive result, frequency of false positive and false negative results,¹⁸³ cost of administering the tests, and estimated numbers and costs of confirmatory neuropsychological evaluations.¹⁸⁴ Costs should be weighed against countervailing individual and societal costs should testing not occur and any potential benefits that could accrue from testing.¹⁸⁵ A decision to test should also take into account the economic and emotional burdens imposed on screened physicians.¹⁸⁶ Moreover, the hospital needs to determine in advance whether the physician, the hospital, or another entity would bear the costs of screening. Consider also that any decision to screen non-discriminatorily and include younger physicians who, as demonstrated in Part I(C), may also manifest cognitive impairment,¹⁸⁷ would amplify all costs.

Finally, cost estimates for case finding require cost comparisons with other modalities for identifying physicians with cognitive impairment, including each modality's false positive and false

181. See Thompson, *supra* note 140, at 390; Powell, *supra* note 19, at 70.

182. Grimes & Schulz, *supra* note 164, at 883 ("Clinicians must know the approximate prevalence of the condition of interest in the population being test tested; if not, reasonable interpretation is impossible.").

183. *Id.* at 882.

184. *Id.* at 883.

185. *Id.* at 881.

186. Le Couteur, *supra* note 27, at 3. See also, Grimes & Schulz, *supra* note 164, at 881.

187. See e.g., Kataria et al., *supra* note 61, at 4-5.

negative rates. If ubiquitous performance surveillance, for example, reliably detects performance or behavioral issues, the balance potentially tilts sharply towards assessment of the individual physician irrespective of age.

III. The Illegality of Age-Based Cognitive Screening Programs for Physicians

Apart from the pragmatic problems described, aged-based screening for older physicians is of questionable legality. A strong likelihood exists that both the ADEA¹⁸⁸ and the ADA prohibit testing of this sort.¹⁸⁹ Before proceeding, it is worth noting that both of these laws, and the closely associated Title VII of the Civil Rights Act of 1964,¹⁹⁰ protect people who fall into the category of 'employee'. Because of the way the medical profession is structured, questions will often arise about whether a particular physician is a covered employee within the meaning of the statute. This discussion will begin by assuming that no such question is present. In terms of the profession, it will assume that the healthcare organization is endeavoring to test its own employees. The subparts of this section will consider treatment of age-based screening under the ADEA and the ADA, and then consider separately the situation where a physician has hospital privileges but is employed by a different legal entity.

A. Age-Related Cognitive Screening Violates the ADEA

1. The ADEA Prohibits Disparate Treatment on the Basis of Age

The ADEA protects workers forty or older¹⁹¹ and forbids employers from discriminating against them on the basis of age. 29 U.S.C. § 623 states, *inter alia*, that:

188.29 U.S.C. § 621 *et. seq.*

189.Americans with Disabilities Act as Amended § 126, 42 U.S.C. § 12112(d) (2009).

190.Civil Rights Act of 1964 (Pub. L. 88-352) (Title VII), as amended, SEC. 2000e-2 (2).

191.29 U.S.C § 621 *et seq.*

It shall be unlawful for an employer -
(1) . . . to discharge . . . or otherwise
discriminate against any individual with
respect to his . . . terms, conditions, or
privileges of employment, because of such
individual's age; (2) to limit, segregate, or
classify his employees in any way which would
deprive or tend to deprive any individual of
employment opportunities or otherwise adversely
affect his status as an employee, because of such
individual's age.¹⁹²

The Supreme Court has made clear that the ADEA
tracks Title VII.¹⁹³ Title VII forbids discrimination
based on "race, color, religion, sex, or national
origin."¹⁹⁴ Three years after its passage, Congress
enacted the ADEA to prohibit discrimination based
on age. In some sense, the ADEA is a follow-up to
Title VII. To be sure, Title VII addresses issues
that represent the most serious of the nation's
normative dilemmas.¹⁹⁵ Although age discrimination
does not have the same historical significance in

192. 29 U.S.C. § 623.

193. See *Transworld Airlines v. Thurston*, 469 U.S. 111, 121 (1985). The later *Gross* decision distinguishes between the two statutes regarding the standard of proof, but does not question their substantive similarity regarding the nature of discrimination.

194. See *Griggs v. Duke Power Company* 401 U.S. 424 (1971) ("The objective of Congress in the enactment of Title VII . . . was to achieve equality of employment opportunities and remove barriers that . . . favor . . . white employees over other employees . . . practices, procedures, or tests neutral on their face, and even neutral in terms of intent, cannot be maintained if they operate to "freeze" the status quo of prior discriminatory employment practices . . . artificial, arbitrary, and unnecessary barriers operate invidiously to discriminate on the basis of racial or other impermissible classifications.").

195. See, ELIJAH ANDERSON AND DOUGLAS S. MASSEY, eds., *PROBLEM OF THE CENTURY: RACIAL STRATIFICATION IN THE UNITED STATES* (2001) (comprising essays on the centrality of race in 20th century U.S.); CHARLES WHALEN & BARBARA WHALEN, *THE LONGEST DEBATE: A LEGISLATIVE HISTORY OF THE 1964 CIVIL RIGHTS ACT* (1989).

our nation as racial discrimination,¹⁹⁶ the two statutes are clearly allied with each other in policy terms. As the Supreme Court declared, “[t]here are important similarities between the two statutes, to be sure, both in their aims—the elimination of discrimination from the workplace—and in their substantive prohibitions. In fact, the prohibitions of the ADEA were derived *in haec verba* from Title VII.”¹⁹⁷

This parallelism between the ADEA and Title VII is instructive. There would not be any doubt that an employer violated Title VII if it required employees of one gender to take a special skills competency test, audited financial transactions only for its salespersons of one faith, or administered a substance abuse test exclusively to employees of one race. Singling out a group of physicians by a protected trait, age, likewise constitutes disparate treatment. It is discriminatory because it relies for its rationale on a stereotype that older physicians are prone to cognitive impairment. The precise purpose of antidiscrimination laws such as Title VII or the ADEA is to eliminate generalizations of this sort.

196. Judicial interpretation of Title VII and the ADEA reflect the relative sensitivities. See e.g., Jacqueline Go, *Another Move Away from Title VII: Why Gross Got It Right*, 51 SANTA CLARA L. REV. 1025, 1048-49 (2011); see also, Jessica Z. Rothenberg & Daniel S. Gardner, *Protecting Older Workers: The Failure of the Age Discrimination in Employment Act of 1967*, 38 J. SOCIOLOGY & SOCIAL WORK 9, 19, 23 (2011).

197. *Lorillard v. Pons*, 434 U.S. 575, 584 (1978) (This statement applied to the substantive provisions of the two laws, and follows the whole code canon of statutory interpretation). See Deborah A. Widiss, *Undermining Congressional Overrides: The Hydra Problem in Statutory Interpretation*, 90 TEXAS L. REV. 859, 874 (“statutory terms should bear consistent meaning across the U.S. Code as a whole.”). Gross has been criticized for its divergence from Title VII interpretation. See, e.g., Charles A. Sullivan, *The Curious Incident of Gross and the Significance of Congress’s Failure to Bark*, 90 TEXAS L. REV. 157, 161 (2012) citing Martin J. Katz, *Gross Disunity*, 114 PENN. ST. L. REV. 857, 871 (2010) (“[Gross] rejected a perfectly reasonable and widely applied canon of construction—the presumption of uniformity—with no good reason for doing so.”)

In *Los Angeles Dep't of Water & Power v. Manhart*,¹⁹⁸ the Court found that the employer violated Title VII and unlawfully discriminated on the basis of sex when the employer justified collecting higher pension contributions from female employees on the grounds that women live longer.¹⁹⁹ The Court reasoned that characteristics of an individual woman and an individual man are not the same as characteristics of the "average" representative within the class of "women" or "men" because other factors affect longevity other than sex.²⁰⁰

Manhart's rationale applies to older physicians. That the average trend is for humans to show cognitive decline over time does not justify using age as a trigger to test for cognitive impairment. Similar to *Manhart*, the inter-individual variability²⁰¹ in cognitive function among physicians renders discriminatory policies that subject all late-career physicians to screening on the basis of generalizations. Furthermore, as Part I of this Article demonstrates, most late-career physicians perform well and some young physicians have evidence of cognitive or other impairment.

2. Age-Related Testing Constitutes Disparate Treatment

Age-related cognitive screening policies impose two conditions of employment on late career physicians to which younger physicians are not subject. First, only older physicians are required to undergo screening, and second, the organization forcibly separates those who refuse screening.²⁰² No younger physicians are placed in this position.

198. *City of Los Angeles, Dept. of Water and Power v. Manhart*, 98 U.S. 1370, 1374 (1978).

199. *Id.* at 1379.

200. *Id.* at 1377.

201. For a discussion on intra-group variability, see *supra* text and accompanying notes 23-25.

202. See, e.g., Sanford, *supra* note 3; CPPPH, *supra* note 88, at 7 (stating in its model guidelines for implementing age-based screening that the policy should "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

Age-related cognitive screening policies also classify physicians in ways that are far from benign. Such classification readily constitutes the type of action that the ADEA prohibits. In *EEOC v. Commonwealth of Massachusetts*,²⁰³ the EEOC brought suit arguing that the state violated the ADEA when it required annual medical examinations for all employees who reached seventy years of age.²⁰⁴ Citing *Western Airlines v. Criswell*,²⁰⁵ the court agreed, pointing out that “[t]he entire point of the ADEA statute is to force employers to abandon previous stereotypes about the abilities and capacities of older workers. Employers . . . may no longer immediately turn to age as a convenient, simple criterion.”²⁰⁶

Of course, employers may make business decisions that burden their entire workforce. There is generally nothing illegal about implementing measures for all employees to ensure that they are competent, honest, and sober. An employer can also justifiably discharge an employee who performs incompetently, steals money, or abuses drugs, but only if monitoring measures are applied on an equal basis. When some particular burden is imposed on a protected group, however, the features of that burden become legally relevant and constitute discriminatory treatment.

In justifying cognitive screening for older physicians, the hospital might argue that the burden of undergoing testing, essentially the inconvenience of giving up part of a workday, is minimal. However, given the asserted premise for the testing, which is that cognitive ability deteriorates progressively as a person ages, an employer would need to re-screen regularly to satisfy its own rationale. By itself, this sort of regular testing is burdensome. Classifying physicians in this way also affects or tends to

failure will result in an incomplete application and lapse of privileges”).

203. *EEOC v. Com. of Mass.*, 987 F.2d 64, 66 (1st Cir. 1993).

204. *Id.* at 66.

205. *Western Air Lines v. Criswell*, 472 U.S. 400, 410 (1985).

206. *EEOC v. Com. of Mass.*, 987 F.2d, at 71.

affect a physician's reputational status.²⁰⁷ By virtue of its explicitly established policy, the organization declares certain medical staff a potential safety threat. For experienced physicians who oversee trainees, consult with colleagues, and wish to inspire confidence in patients and staff alike, the result is likely embarrassment at best, and at worst potentially damaging to their ability to fulfill their roles.

Moreover, beyond the burdens and emotional implications of being subject to the testing, the testing itself has other significant consequences for the physicians. As seen in Part II, there is no simple and reliable screening test for highly educated and experienced individuals, and false positive and false negative tests will occur. Certainly, inaccuracies plague all instruments and methodologies. However, taking adverse employment actions that would deprive or have the effect of depriving individuals from employment opportunities—such as threatening or restricting clinical privileges, even if temporary, based on an unreliable cognitive screen—violates the ADEA. In such a case, the plaintiff-employee could readily demonstrate that if not for the employer's use of age as an explicit basis for testing, the employer would not have subjected the employee to further adverse employment action.

Although perhaps somewhat counterintuitive, even the accurate detection of cognitive impairment among older physicians tested en masse would likely violate the ADEA because the testing would not include the non-targeted physicians. There is no convincing evidence that older physicians suffer from cognitive impairment at a high rate, and impairing conditions are found in physicians of any age. Therefore, taking action like restricting privileges against members of one group without taking the same action against others who are similarly situated is unlawful discrimination. The ADEA requires that the employer's actions do not single out this protected group, older physicians, for increased scrutiny.

207.29 U.S.C § 623 (a) (2) (2017) .

3. Employers Cannot Assert Any Valid Defense

Employers might assert four types of exceptions to an ADEA claim²⁰⁸: first, that performing cognitive screening on older physicians does not rise to the level of disparate treatment; second, that the employer based its actions on a "reasonable factor other than age" or "RFOA"²⁰⁹; third, that a trait is a bona fide occupational qualification ("BFOQ")²¹⁰; or fourth, that one of the ADEA's occupational exceptions applies.²¹¹

a. *The Defense that Age-Based Screening is not Disparate Treatment is Invalid*

Through judicial interpretation, courts have established significant hurdles for the plaintiff-employee to overcome to prevail on disparate treatment claims under the ADEA. In *Hazen Paper Co. v. Biggins*,²¹² the U.S. Supreme Court required that the plaintiff demonstrate that the employer intentionally acted because of the employee's age.²¹³ In *Gross v. FBL Financial Services*,²¹⁴ the Court, in an opinion by Justice Thomas, imposed an even higher standard for the plaintiff, holding that "a plaintiff must prove that age was the 'but-for' cause of the employer's adverse decision."²¹⁵ Thus,

208. See 29 U.S.C. 623 (f) (1) (2017).

209. 29 U.S.C. 623 (f) (1) (2017).

210. *Id.*

211. 29 U.S.C. 623(j) (2017).

212. *Hazen Paper Co. v. Biggins*, 507 U.S. 604, 610 (1993).

213. *Hazen*, 507 U.S. at 617. See also *Kentucky Retirement Systems v. EEOC*, 554 U.S. 136, 147-48 (2008) (holding that discharge of an employee due to his pension status does not, by itself, constitute a violation of the ADEA because pension benefits and age are analytically distinct); Joseph A. Seinert, *Disentangling Disparate Impact and Disparate Treatment: Adapting the Canadian Approach*, 25 YALE L. & POL'Y REV. 90, 96 (2006).

214. *Gross v. FBL Financial Services Inc.*, 557 U.S. 167 (2009).

215. *Gross*, 557 U.S. at 180 (In reaching this conclusion, Justice Thomas relied on the ordinary language analysis, replete with dictionary citations that the current Court favors so heavily. He said: "The ordinary meaning of the ADEA's requirement that an employer took adverse action

the burden of proof remains with the plaintiff who must demonstrate, by a preponderance of the evidence, that the employer acted solely on the basis of the employee's age.²¹⁶ A jury might find that causation, for example, when the employer expressed a preference for younger employees,²¹⁷ a desire for a different style of performance,²¹⁸ a concern that the employee has "been there too long,"²¹⁹ or a query that "you're 64, how much longer are you going to work."²²⁰ If the plaintiff cannot prove age as the "but-for" reason for the employment action, *Gross* disallows recovery even if the employer had "mixed motives" because the holding eliminates any need for the defendant to show she would have taken the action against the employee regardless of his age.²²¹

While *Gross* increases the difficulty for a plaintiff to prevail in a disparate treatment ADEA

'because of' age is that age was the 'reason' that the employer decided to act.").

216. *Id.*

217. *Scheick v. Tecumseh Public Schools* 766 F.3d 523, 531-532 (6th Cir. 2014) ("[S]tatements about wanting 'someone younger' are not ambiguous . . . [Plaintiff] presented evidence, which, if believed, would require the conclusion that age was the but-for cause of TPS's decision not to renew the contract."). See also *General Dynamics Land Systems, Inc. v. Cline*, 540 U.S. 581, 600 (2004) (ADEA does not prevent an employer from favoring an older employee over a relatively younger one).

218. *U.S. EEOC v. Century Broadcasting Corp.*, 957 F. 2d 1446, 1450 (7th Cir. 1992).

219. *Schindler v. Bierwith Chrysler/Plymouth Inc.*, 15 F. Supp. 2d 1054, 1056 (D. Kan. 1998).

220. *Smith v. Chester County Bd. Of Educ.* 218 F.Supp.3d 619, 625, 630 (W.D. Tenn. 2016) ("[R]emark during . . . interview, which Plaintiff recounts as "you're 64, how much longer are you going to work," constitutes direct evidence of age discrimination . . . a reasonable jury could find that age was the "but-for" cause of the adverse employment action . . .").

221. "The burden of persuasion does not shift to the employer to show that it would have taken the action regardless of age, even when a plaintiff has produced some evidence that age was one motivating factor in that decision." 557 U.S. at 180.

claim,²²² it does not make an age-based cognitive testing program any more permissible. Age is clearly the “but-for” reason for the testing. If there were some other basis for administering the test, then some physicians above the screening age would not be tested and some physicians below that age would be. Thus, even according to the Supreme Court’s demanding standards for disparate treatment ADEA actions, age-based screening violates the Act.²²³

*b. The Reasonable Factor Other than Age (RFOA)
Defense is Unavailable*

Employers might assert that screening older physicians for cognitive impairment is based on an RFOA.²²⁴ However, the ADEA demands²²⁵ that the employer’s RFOA is an accurately defined non-age factor that the employer applies “fairly and accurately.”²²⁶ Further, the employer must assess the adverse impact of the practice on older workers and take steps to reduce that harm.²²⁷

222. William R. Corbett, *Babbling About Employment Discrimination Law: Does The Master Builder Understand The Blueprint For The Great Tower?*, 12 UNIV. PA. J. BUS. L. 683, 728-29 (2010) (arguing that after *Gross*, which diverged from the long lines of cases interpreting the ADEA consistent with Title VII, Congress needs to clarify the law).

223. Congress amended Title VII to overrule the Court’s decision in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), (see Civil Rights Act of 1991, §§ 2000e-2(m) and 2000e-5(g)(2)(B)), but did not amend the ADEA along the same lines. This does not alter the Court’s conclusion that the substantive language of both statutes is equivalent.

224. 29 C.F.R. 1625.7; See *Meacham v. Knolls Atomic Power Laboratory*, 554 U.S. 84, 87 (2008) (holding that the RFOA defense is an affirmative one, for which employers bear the burdens of production and persuasion.).

225. See Stephen D. Erf, *New EEOC Rule Significantly Increases Employer Burdens in ADEA Disparate Impact Cases*, MCDERMOTT WILL & EMERY (May 29, 2012), <https://www.mwe.com/en/thought-leadership/publications/2012/05/new-eeoc-rule-significantly-increases-employer-burdens>.

226. 29 C.F.R. 1625.7 (e)(2)(ii).

227. 29 C.F.R. 1625.7 (2) (iv-v).

The defendant-employer would likely claim that given its legitimate business interest to provide safe patient care, a screening program based on the RFOA of needing to assure that its physicians are not cognitively impaired is reasonably related to safe care.²²⁸ The problem for the hospital is that if it is justified in searching for physicians who pose risk to patients because of cognitive impairment, then the law demands that it also search for any physician who poses similar risk—not just those in their late career.

Furthermore, an employer who fires a physician who refuses to undergo testing has not seriously considered the adverse impact of the testing practice on older workers nor has taken any steps to reduce that harm. It is one thing for a hospital to have a policy that removes a physician who refuses to submit to assessment when the reason for the mandated assessment is evidence of a problem. It is another thing to administer a draconian penalty in the absence of such evidence. Finally, if the employer uses age as the limiting criterion for the practice, as in this case where there is an established age in the policy when screening will begin, the RFOA exception to the ADEA would not be available to the employer.²²⁹

*c. The Bona Fide Occupational Qualification ("BFOQ")
Defense is Unavailable*

Given that cognitive testing falls within the category of prohibited disadvantages that may not be imposed on an age-related basis, the employer may justify it by claiming that intact cognitive skills are a bona fide occupational qualification (or "BFOQ") for the physicians it employs. The statutory test for a BFOQ under the ADEA is whether it is "reasonably necessary to the normal operation of the

228. See Ninth Circuit Jury Instruction Committee, *11.11 Age Discrimination - Defenses - Reasonable Factor other than Age*, in *MANUAL OF MODEL CIVIL JURY INSTRUCTIONS FOR THE DISTRICT COURTS OF THE NINTH CIRCUIT* (last updated Mar. 2018).

229. 29 C.F.R. 1625.7 (b) ("When an employment practice uses age as a limiting criterion, the defense that the practice is justified by a reasonable factor other than age is unavailable.").

particular business.”²³⁰ Courts uniformly hold that this exception to the ADEA’s general prohibition of age discrimination is “extremely narrow.”²³¹ The leading articulation of this narrow construction was by the Fifth Circuit in *Usery v. Tamiami Trail Tours, Inc.*²³² In considering whether a bus-tour company could refuse employment applications from individuals over the age of 40, the Fifth Circuit used a two-prong test to determine if the BFOQ defense applied to the employer’s assertion of public safety as its BFOQ.²³³ First, “the job qualifications which the employer invokes to justify his discrimination must be *reasonably necessary* to

230. 29 U.S.C. § 623(f) (2016) (“It shall not be unlawful for an employer, employment agency, or labor organization-

(1) to take any action otherwise prohibited under subsections (a), (b), (c), or (e) of this section where age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business.”).

231. See *Western Airlines, Inc. v. Criswell*, 472 U.S. 400, 412 (1985) (“[L]ike its Title VII counterpart, the BFOQ exception ‘was in fact meant to be an extremely narrow exception to the general prohibition’ of age discrimination contained in the ADEA.”) (quoting *Dothard v. Rawlinson*, 433 U.S. 321 (1977), a Title VII case that first construed the BFOQ exception); *Gately v. Com. of Mass.*, 2 F.2d 1221, 1225 (1st Cir. 1993), *cert. denied*, 511 U.S. 1082 (1994) (holding that this clause is “an extremely narrow exception to the general prohibition of age discrimination contained in the ADEA.”) (quoting *Western Air Lines v. Criswell*, 427 U.S. 400 (1985)); *Orzel v. City of Wauwatosa Fire Dep’t*, 697 F. 2d 743, 748 (7th Cir., 1982), *cert. denied*, 464 U.S. 992 (1983) (“[. . .]the courts have consistently held that the BFOQ exception to the ADEA is to be interpreted narrowly[. . .]”); *Smallwood v. United Airlines, Inc.*, 661 F.2d 303, 307 (4th Cir., 1981), *cert denied*, 456 U.S. 1007 (1982) (“This exception is to be narrowly applied.”); *Camacho v. Puerto Rico Port Auth.*, 254 F. Supp. 2d 220, 229 (D. Puerto Rico, 2003), *rev’d*, 369 F.3d 570 (1st Cir. P.R. 2004) (“[T]he BFOQ defense is meant to be an extremely narrow exception to the ADEA’s general prohibition.”).

232. *Usery v. Tamiami Trail Tours, Inc.*, 531 F.2d 224, 227 (5th Cir. 1976).

233. *Id.* at 235-36.

the essence of his business.”²³⁴ Second, the defendant must show either that (a) it had reasonable cause to believe that all or substantially all older employees were not qualified²³⁵ or (b) that it was impossible or impractical to individually ascertain the presence of a disqualifying trait.²³⁶

The Supreme Court adopted this two-prong test in *Western Airlines, Inc. v. Criswell*.²³⁷ In 1992, the Equal Employment Opportunity Commission (“EEOC”), which was charged with implementing the ADEA, incorporated this test into its regulations, along with an instruction that the BFOQ exception “must be narrowly construed.”²³⁸ The EEOC regulations made clear that, “[i]f the employer’s objective in asserting a BFOQ is the goal of public safety, the employer must prove that the challenged practice does indeed effectuate that goal and that there is no acceptable alternative which would *better advance or equally advance it with less discriminatory impact*.”²³⁹

The two-prong analysis is readily applied to the case in which a healthcare organization wants to screen all of its older physicians for cognitive impairment. Because defects in neurocognitive functioning can impact the ability to practice medicine safely, no one would disagree that requiring physicians to be cognitively competent is a job qualification reasonably necessary to the healthcare business. The first prong for a BFOQ defense is therefore satisfied.

The second prong of the test for using a BFOQ defense, however, is not met. Testing proponents

234. *Id.* at 230.

235. The defendant in *Usery*, for example, would have had to show that substantially all older drivers have traits that would interfere with safety and efficiency. *Id.* at 235-37.

236. *Id.* at 228.

237. *Western Air Lines v. Criswell*, 472 U.S. 400, 417-418 (1985) (stating that the employer asserted public safety as its BFOQ).

238. 29 C.F.R. § 1625.6(b) (2017).

239. *Id.* (emphasis added).

cannot demonstrate that age represents a proxy for a valid safety-related job qualification because they cannot make a factual finding that all or substantially all of those who are above a defined age limit have a trait that threatens safety. As seen, many older physicians choose not to retire and continue to do well in practice. Furthermore, claiming a BFOQ to screen all physicians above a certain age is self-refuting, because such a program rests on the premise that individualized assessment is neither impossible nor impractical.

Thus, to avoid the ADEA's prohibition against age discrimination and satisfy its own standards for precaution, the healthcare employer would need to have options in place other than age-based testing. One option would be to administer cognitive screening to all of its physician employees.²⁴⁰ Should the employer not wish to do so, the employer should explore other methodologies to monitor all physicians for safe performance.²⁴¹

d. Analogy to Statutory Exceptions for Public Safety Officers and Airline Pilots is Inapplicable

Certain groups of employees are expressly excluded from relevant parts of ADEA coverage, either by provisions of the ADEA (e.g., firefighters and law enforcement officers)²⁴² or by other federal

240. See *EEOC v. Kentucky State Police Dep't*, 860 F.2d 665, 667 (6th Cir., 1988) (holding cardiovascular fitness cannot be regarded as a valid reason for mandatory retirement age because the police department does not test officers below that age for this condition); *EEOC v. Commonwealth of Pennsylvania*, 829 F.2d 392, 395 (3rd Cir., 1987) (finding that good health and physical conditioning cannot be a valid reason for mandatory retirement age if the police department has failed to develop minimum fitness standards).

241. See *infra* Part IV.

242. 29 U.S.C 623(j) (2012) (providing that, with respect to firefighters and law enforcement officers, states may "fail or refuse to hire or to discharge any individual because of such individual's age . . . [T]he employer has complied with section 3(d)(2) of the Age Discrimination in Employment Amendments of 1996 if the individual was discharged after the date described in such section, and the individual has attained . . . the higher of . . . the age of retirement in effect on the

statutes and regulations (e.g., commercial airline pilots and air traffic controllers).²⁴³ Because physicians are responsible for the health, and sometimes life or death, of their patients, some compare physicians to professionals like pilots who are excluded from the ADEA's protections.²⁴⁴ However, this argument is unconvincing for exempting physicians from the ADEA.

By its terms, the ADEA permits age-based hiring and discharge of "an individual employed as a firefighter or as a law enforcement officer."²⁴⁵ The original ADEA was amended in 1974 to cover federal, state and local governments.²⁴⁶ When it was amended again to prohibit mandatory retirement based on age, it made an exception for public employees deemed responsible for public safety, namely police and

date of such discharge under such law; and . . . age 55."); see also, *Special Retirement Provisions for Law Enforcement Officers, Firefighters and Air Traffic Controllers: A Guide for Human Resources Specialists*, Benefits and Entitlements Branch, DEFENSE CIVILIAN PERSONNEL MANAGEMENT SERVICE 1, 4, 14, 20 (2006) ("The legislative intent behind the special retirement provisions for LEOs and FFs was to provide for their early retirement based on a determination that these positions should be composed . . . of young men and women physically capable of meeting the vigorous demands of occupations that are more physically taxing than most in the Federal service.")

243.49 U.S.C. § 44729 (a) (2017) ("a pilot may serve in multicrew covered operations until attaining 65 years of age"); 5 U.S.C. § 8335(a) (providing that the mandatory retirement age for air traffic controllers is 56). See also JODY FEDER, CONGRESSIONAL RESEARCH SERVICE, *THE AGE DISCRIMINATION IN EMPLOYMENT ACT (ADEA): A LEGAL OVERVIEW* (2010), at 3-4.

244. The medical literature addressing the issue of age-based screening for physicians repeatedly raises a comparison between pilots and physicians. See, e.g., Haddad, *supra* note 35, at 16; Blasier, *supra* note 110, at 407; LoboPrabhu, *supra* note 6, at 446; E. Patchen Dellinger et al., *The Aging Physician and the Medical Profession*, 152 *JAMA SURGERY* 967, 968 (2017).

245.29 U.S.C 623(j) (1996).

246. Fair Labor Standards Act Amendments of 1974, Pub. L. No. 93-259, §§ 28(a) (2-3), (b) (2) (codified as amended at 29 U.S.C. §§ 630(b), 633(a)).

firefighters.²⁴⁷ In doing so, Congress charged the EEOC with investigating what measurements could determine the physical and mental fitness of public safety officers so that individualized assessments could be implemented later.²⁴⁸ The EEOC commissioned Penn State University's Center for Applied Behavioral Sciences²⁴⁹ to explore whether mandatory retirement ages for public safety jobs were justified.²⁵⁰ The study group concluded that age was not a predictor of job performance, and neither the Penn State researchers nor the EEOC could determine what tests would validate fitness of public safety officers.²⁵¹ Therefore, the public safety exception to the ADEA remains a self-contained statutory provision²⁵² with no underlying principle that can

247. 29 U.S.C. § 631(j) (1988).

248. Ron Edwards, *Mandatory Retirement: Police, Fire Fighter and Tenured Faculty*, 53 PUB. ADMIN. REV. 404, 404 (1993).

249. *Id.* See also, Martin Schiff, *The Age Discrimination in Employment Act: Whither the Bona Fide Occupational Qualification and Law Enforcement Exemption?*, 67 ST. JOHN'S L. REV. 13, 16-17 (1993).

250. Edwards, *supra* note 248.

251. See Center for Applied Behavioral Sciences, Penn State University, *Alternatives To Chronological Age In Determining Standards Of Suitability For Public Safety Jobs: Executive Summary Of Medical Section*, 8-18 (1992); see also Cheryl Anthony Epps, *Legislative Alert: Penn State Study Recommends Elimination of ADEA Public Safety Exception*, POLICE CHIEF 14, 14 (May 1992) (providing a detailed analysis of the study).

252. After the ADEA was amended to extend to federal, state, and local governments, Fair Labor Standards Amendments of 1974, Pub. L. No. 93-259, §§ 28(4) and 14(a), 88 Stat. 74-5 (1974), it was further amended to exclude police officers and firefighters from certain portions of its coverage, Age Discrimination in Employment Amendments of 1986, Pub. L. No. 99-592, § 3(a), 100 Stat. 3342 (1986). This indicates that if Congress wants to exclude any given profession from the full force of the ADEA, it knows exactly how to do so. The more cynical, public choice interpretation is that state and local governments, or police and fire departments were particularly effective lobbyists. That same public choice analysis suggests, however, that the statutory indulgence they obtained should not be extended to employers who were unable to bargain for it. See

be extended by analogy to a group of employees who carry out quite different functions. Analogies in our legal system depend on identifying an underlying principle by which the different cases can be regarded as legally equivalent.²⁵³ The EEOC's unsuccessful efforts to identify a valid test for fitness suggests that there is no such principle.

Neither courts nor agencies have been willing to expand these exceptions from the coverage of the ADEA beyond their explicit boundaries. They have concluded that airline pilots are a category of employee specifically excluded from the terms of the ADEA by separate statutory enactment, and therefore, in effect, subject to a particular BFOQ under the ADEA.²⁵⁴ Beginning in 1959, a Federal Aviation Administration (FAA) regulation established the mandatory retirement limit for pilots at a maximum age of sixty.²⁵⁵ Courts treated this rule as a BFOQ as a matter of law that could not be challenged under the ADEA.²⁵⁶ In 2007, Congress enacted the Fair Treatment for Experienced Pilots Act (the "Age 65 Law"),²⁵⁷ which raised the mandatory retirement age to sixty-five and established it as definitive.²⁵⁸

generally Dennis C. Mueller, PUBLIC CHOICE III, 472-97 (2003).

253. See MELVIN EISENBERG, THE NATURE OF THE COMMON LAW 76-83 (1991).

254. See 49 U.S.C. §44729 - Age Standards for Pilots.

255. 14 C.F.R. § 121.383(c) (1987) ("No person may serve as a pilot on an airplane engaged in operations . . . if that person has reached his 60th birthday.").

256. See, e.g., EEOC v. Boeing Co., 843 F.2d 1213, 1220 (1988) (holding that FAA Age-60 rule for commercial pilots does not necessarily apply to pilots of corporate aircraft); EEOC v. El Paso Natural Gas Co., 626 F. Supp. 182, 186-87 (W.D. Tex., 1985) (explaining that the FAA Age-60 rule is relevant evidence to the company's claim that its own Age-60 rule is a BFOQ).

257. Fair Treatment for Experienced Pilots Act, Pub. L. 110-135, 49 U.S.C. § 44729 (2007).

258. Prior to this change, the Federal Aviation Administration had asked for input from the EEOC as to whether age 60 could be supported as a BFOQ. The EEOC confirmed that it could not as, as there was no evidence of an increase in accident rate as pilots neared age 60. The EEOC made clear that it favored the elimination entirely of upper age limits for commercial airline pilots, as individualized assessment for pilots of all

That this age-related presumption about pilot competency was established, first by regulation and then by statute, indicates that Congress and the courts understood that such presumptions would be otherwise forbidden under current law, even for commercial airline pilots.

While the mandatory retirement age for commercial pilots is outside the reach of the ADEA, the Fifth Circuit Court of Appeals in *EEOC v. Exxon Corporation*²⁵⁹ decided that the company could mandate retirement of its pilots as a BFOQ.²⁶⁰ The Fifth Circuit rejected an ADEA challenge, basing its decision on the existence of the FAA regulation, the absence of any material difference between piloting a corporate plane and piloting a commercial plane, and the fact that corporate pilots and commercial pilots share the same airspace.²⁶¹ The court extended these principles by analogy, as it saw no functional difference between the groups and therefore found them legally equivalent. If the company's activity had been functionally distinguishable, the result might have been different.²⁶²

Granted, the focus for age-based screening proponents is not on implementing a mandatory retirement age for physicians. However, some argue that the functional similarities between pilots and physicians—like requiring a sophisticated skill set and working in settings where death and other grave harms could result from error—are sufficient to

ages could assess skills and health, but had agreed to age 65 as an interim step towards that goal. See U.S. Equal Emp. Opportunity Comm'n, Opinion Letter on FAA Age 60 Rule (Nov. 15, 2006), https://www.eeoc.gov/eeoc/foia/letters/2006/adea_individualizedassessment_faa60rule.html.

259. *EEOC v. Exxon Mobil Corp.*, 560 Fed. Appx. 282, 290 (5th Cir. 2014).

260. *Id.* at 289.

261. *Id.* at 287.

262. One final factor that limits analogies to *EEOC v. Exxon* is that Congress had granted the EEOC an opportunity to provide alternatives to using age as a BFOQ for predicting which pilots over 60 would be at risk for sudden incapacitation. Because the EEOC ultimately did not offer such recommendations, age as a BFOQ was preserved. 49 U.S.C. § 44729 (g)(1) (2007).

justify discriminating against older physicians and to allow testing that would assure cognitive and technical competence.²⁶³ The analogy, however, is weak. The statutes and regulations to which pilots are subject, including mandatory health and skills monitoring,²⁶⁴ seem to distinguish them from other professions. People in many jobs, including taxicab drivers and construction equipment operators can also cause death or injury if they lost functionality or worked in an impaired state.²⁶⁵ In view of Congress' specific motivations for treating pilots differently, no analogy between physicians and pilots justifies removing older physicians from the ADEA's protections.

Some proponents of age-based testing might also invoke the Age Discrimination Act of 1975 (the "ADA 1975")²⁶⁶ to argue that screening for cognitive

263. See, e.g., Maryn McKenna, *Aging Gracefully? Patient Safety Advocates Call for Ongoing Skills Assessments for Older Physicians*, 58 ANNALS EMERGENCY MED. 3 (2011); Scott Humphreys & Doris C. Gundersen, *The Aging Physician*, 12 NEWSLETTER OF THE COLORADO PHYSICIAN HEALTH PROGRAM (Summer 2013). Donald D. Trunkey, *Assessing Competency: A Tale of Two Professions*, 192 J. AM. COLL. SURGEONS 385, 392 (2001).

264. 14 C.F.R. § 67(2017); see also *Synopsis of Medical Standards*, FED. AVIATION ADMIN. (Apr. 3, 2006), https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/standards/; 49 U.S.C. § 44729 (g)(1) (2017) (requiring all pilots, irrespective of age, to undergo the same frequency of medical examinations and to meet the same medical standards); 16 C. F. R. §61.56 (c) (2012) (providing for biannual piloting skills review).

265. In fact, physicians typically may be less likely to cause harm due to sudden incapacity than some of these other occupations because physicians tend to work with a team with other healthcare professionals who can step in if needed.

266. Age Discrimination Act of 1975, 42 U.S.C. §§ 6101-6107 (2011); 34 C.F.R. § 110(2016). § 6102 states that "[p]ursuant to regulations prescribed under section 6103 of this title, and except as provided by section 6103(b) of this title and section 6103(c) of this title, no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance (emphasis added).

impairment is authorized. This statute, enacted after the ADEA, applies to "any program or activity receiving Federal financial assistance," which includes hospitals as recipients of Medicare and Medicaid payments.²⁶⁷ While it prohibits discrimination on the basis of age, it allows for exceptions if the federally assisted program or activity "reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity."²⁶⁸

The ADA 1975, however, does not permit a healthcare organization to conduct age-based testing for three reasons. First, because age is not predictive of performance, it cannot be a factor necessary to an organization's operations or achievement of goals. Second, the goals of most healthcare organizations, although important, are not statutory. Third, and most importantly, the statute expressly states that "[n]othing in this chapter shall be construed to amend or modify the Age Discrimination in Employment Act of 1967 as

267. See 42 C.F.R. 489.10 (a) (2017) ("Any of the providers specified in § 489.2 may request participation in Medicare . . . (b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of . . . (3) the Age Discrimination Act of 1975 . . . "); 42 C.F.R. 489.2(b) (2017) ("The following providers are subject to the provisions of this part: (1) Hospitals . . . "). See also, Phoebe W. Williams, *Age Discrimination in the Delivery of Health Care Services to Our Elders*, 11 MARQUETTE'S ELDER ADVISOR 1, 28 (2009).

268. 42 U.S.C. § 6103 (b) (1) (A) (2011). See also Jessica D. Silver, *From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the "Hidden" Rationing of Medical Care*, 37 CATHOLIC UNIV. L. REV. 993, 1031. Under 45 C.F.R. § 90.14 (1987), the test for the "normal operation" exception of the ADA 1975 has four elements. The elements are evocative of the *Tamiami* test to allow the BFOQ exception to the ADEA. The exception is allowed if: (a) Age is used as a measure or approximation of one or more other characteristics; and (b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue . . . ; and (c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and (d) The other characteristic(s) are impractical to measure directly on an individual basis.

amended, or to affect the rights of responsibilities of any person or party pursuant to such Act.”²⁶⁹ That is, the ADA 1975 applies anti-discrimination protections in contexts other than employment,²⁷⁰ for example, educational institutions.²⁷¹ In the healthcare context, the ADA 1975 might allow restricting applications, on an operational basis, from high school students under the age of fifteen who wish to volunteer, but it cannot be reasonably read as justifying age-based testing of late-career physicians protected by the ADEA.

B. Age-Related Screening and the ADA

In addition to its violation of the ADEA, age-based screening for cognitive impairment is also likely to violate a second major federal law, the ADA,²⁷² because such screening (1) ignores prohibitions that prevent employers from requiring medical examination of existing employees without

269. 42 U.S.C. § 6103 (c) (2) (2017).

270. See *Action Alliance v. Heckler* 789 F.2d 931 (1986), n. 1 (“The ADA [1975] prohibits discrimination with regard to any type of benefit but applies only to ‘programs or activities receiving Federal financial assistance.’ The ADEA, on the other hand, proscribes discrimination only in relation to employment.”). See also Silver, *supra* note 268, at 1043 (The ADA [1975] involves both employment opportunities and programs providing benefits to individuals).

271. See *Age Discrimination: Overview of the Law*, U.S. DEP’T EDUC., <http://www2.ed.gov/policy/rights/guid/ocr/ageoverview.html> (last updated Oct. 15, 2015). See also *Cannon v. Univ. of Health Sciences* 710 F.2d 351 (1984) (“(HEW) . . . interpretive regulations . . . specified that age could not be considered by medical schools in making admission decisions. 45 C.F.R. Part 90 (1979).”).

272. 42 U.S.C. § 12101 *et. seq* (2017); US Dep’t of Justice Civil Rights Div., *Employment (Title I)*, ADA, https://www.ada.gov/ada_title_I.htm (last visited Apr. 9, 2018) (Title I of the ADA “prohibits private employers, State and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. The ADA covers employers with 15 or more employees.”).

cause and (2) misconstrues the “business necessity” defense.

1. ADA Prohibitions

The ADA is clear that an employer may conduct a job-related medical inquiry and examination after making an employment offer but before employment begins only if all entering employees are subject to such an evaluation.²⁷³ Thus, physicians can be subject to an employer-mandated medical examination²⁷⁴ related to their ability to perform the essential functions of the job²⁷⁵ with or without the need for “reasonable accommodation.”²⁷⁶ An accommodation is a change in the work environment or a change from the customary way of doing things that allows a person with a disability to do the job.²⁷⁷ The employer is only obligated to provide reasonable accommodations that do not create “undue hardship” for the employer.²⁷⁸ Whether the accommodation will impose undue hardship depends on a variety of factors that include the cost of the accommodation relative to the resources of the company, the type of operations that the company engages in, and the impact the accommodation will

273. 42 U.S.C. § 12112 (d) (2)-(3) (2017).

274. The use of various pre-employment tests is widespread, and apparently increasing. See Kimberli R. Black, *Personality Screening in Employment*, 32 AM. BUS. L. J 69, 69 (1994); Susan J. Stabile, *The Use of Personality Tests As a Hiring Tool: Is the Benefit Worth the Cost?*, 4 U. PA. J. LAB. & EMP. L. 279, 287 (2002). Although such testing is explicitly permitted by the ADA, questions have been raised about whether it can be used to circumvent the ADA prohibitions. See Sujata S. Menjoge, *Testing the Limits of Anti-Discrimination Law: How Employers Use of Pre-Employment Psychological and Personality Tests Can Circumvent Title VII and the ADA*, 82 N.C.L. REV. 326, 329 (2003).

275. 42 U.S.C. §12111(8) (2009); 29 C.F.R. §. 1630.2(n) (2016).

276. 42 U.S.C. §12111(9) (2017); 29 C.F.R. § 1630.2(o) (1) (2016); 29 C.F.R. pt. 1630 app. § 1630.2(o) (1997).

277. Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act (Oct. 17, 2002).

278. 29 C.F.R. §1630.15(d) (2017).

have on the operation of the facility.²⁷⁹ Reasonable accommodation may include providing physically accessible facilities for employees with disabilities, modified work schedules, equipment modification, and readers or interpreters.²⁸⁰

Once the person begins work, however, employers are restricted in what they may ask or require of the employee related to medical issues.²⁸¹ Section 12112(d) (4) (A) of the ADA states that:

A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.²⁸²

Significantly, the ADA covers perceived disability as well, stating:

An individual meets the requirement of 'being regarded as having such an impairment' if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.²⁸³

Thus, being viewed, labeled, treated, or spoken of as disabled entitles an individual to ADA protections, even if the individual has no

279.29 C.F.R. §1630.2(p) (2) (2017).

280.42 U.S.C. §12111 (9) (2017).

281.42 U.S.C. §12112(d) (4) (A) (2017) .

282.42 U.S.C. § 12112(d) (4) (A) (2017). See *Bates v. Dura Automotive Systems, Inc.*, 767 F.3d 566, 573 (6th Cir. 2014) (holding "subsection (d) (4) prohibits employers from requiring medical examinations and disability inquiries "of an employee," regardless of whether (s)he has a disability").

283.42 U.S.C. § 12102(3) (A) (2017); See also 29 C.F.R. § 1630.2(g) (2017).

disability in fact.²⁸⁴ Congress made it clear that "[t]his section of the definition of disability was meant to express our understanding that unfounded concerns, mistaken beliefs, fears, myths, or prejudice about disabilities are often just as disabling as actual impairments, and our corresponding desire to prohibit discrimination founded on such perceptions."²⁸⁵

A crucial question is whether the terms within Section 12112(d)(4)(A) apply only to situations arising on an individual basis because both the statute and regulations refer to "an employee" rather than "employees". The alternative is that the employer could inquire into and examine groups of employees by claiming the need to ensure that each person within that group could still perform the essential functions of the job with or without a reasonable accommodation.

284. It should be noted, however, that courts have not been particularly receptive to claims under the "regarded as" provision. See *Foreman v. Babcock & Wilcox Co.*, 117 F.3d 800, 806 (5th Cir. 1997); *Gordon v. E.L. Hamm & Assocs., Inc.*, 100 F.3d 907, 912-13 (11th Cir.1996), cert. denied, 522 U.S. 1030 (1997); *Kelly v. Drexel Univ.*, 94 F.3d 102, 109 (3d Cir.1996); *Wooten v. Farmland Foods*, 58 F.3d 382, 385 (8th Cir.1995) (The reason may be that this claim depends upon the employer's subjective attitude, which is difficult to prove. Testing physicians above a given age for cognitive impairment, however, might well be a situation where this claim would be well-founded. It would be difficult for a healthcare organization to explain this policy without claiming that it regards all older physicians as likely to be suffering from such a disability.).

285. 154 CONG. REC. S88, 42 (daily ed. Sept. 16, 2008) (statement of Sen. Harkin). In Appendix A to Part 35 of the Code of Federal Regulations, the Department of Justice expands on this statement by stating that "although an individual may have an impairment that does not in fact substantially limit a major life activity, the reaction of others may prove just as disabling." 28 C.F.R. pt. 35, appx. A (2010) citing *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 283 (1987) (superseded by statute). The Department of Justice continued by stating that: "a person who is denied services or benefits by a public entity because of myths, fears, and stereotypes associated with disabilities would be covered" by the ADA under the "regarded as" portion of the definition of disability. 28 C.F.R. pt. 35, appx. A (2010).

The Enforcement Guidance from the EEOC²⁸⁶ takes the first position, that the ADA generally does not allow disability-related inquiries or medical examinations of employees except when the employer has a reasonable belief based on evidence that a particular individual is suffering from a medical condition that impairs job performance or poses a "direct threat."²⁸⁷ The ADA defines "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."²⁸⁸ The employer's reasonable belief may be based on direct observation or reliable information.²⁸⁹ The EEOC's stance is that inquiry and examination are not to be used to determine whether an employee has a disability where there is no reason to suspect one. This means the employer can only make inquiries and require job-related examinations on a "for cause" basis. If an employer cannot conduct a "fishing expedition" on an individual employee, it certainly cannot require testing of an entire group of physicians over a certain age because of a perception²⁹⁰ they are likely to suffer from cognitive impairment. Furthermore, it would seem implausible that the employer could have observational or informational evidence for every member of the group that would justify making disability-related inquiries or

286. EEOC Enforcement Guidance No. 915.002, Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA) (2000), available at <http://eeoc.gov/policy/docs/guidance-inquiries.html> [hereinafter EEOC Guidance].

287. See *id.*

288. 42 U.S.C. § 12111(3). With respect to healthcare workers, courts have held that conditions posing a direct threat include attention deficit hyperactivity disorder (ADHD). See *Robertson v. Neuromedical Ctr.*, 161 F.3d 292, 296 (5th Cir., 1998); for HIV infection, see *Estate of Mauro By and Through Mauro v. Borgess Med. Ctr.*, 137 F.3d 398, 411 (6th Cir. 1998); for alcoholism, see *Bekker v. Humana Health Plan, Inc.*, 229 F.3d 662, 671-72 (7th Cir. 2000); and for drug addiction, see *Dovenmuehler v. St. Cloud Hosp.*, 509 F.3d 435, 438 (8th Cir., 2007).

289. See EEOC Guidance, *supra* note 286, at A5-6.

290. See 42 U.S.C. § 12112(d) (4) (A) (2017).

ordering job-related exams. Therefore, these mass inquiries or examinations would constitute disability discrimination under the ADA.

2. The "Job-Related and Consistent with Business Necessity" Defense

The ADA and its implementing regulations do not define when a periodic medical examination or inquiry is "job-related and consistent with business necessity."²⁹¹ A proponent of age-based testing might argue that employers can conduct en masse screening if relevant and essential to the business. Yet this interpretation is too broad, because the EEOC Enforcement Guidance limits the occupations for which it allows periodic medical examinations, and only expressly allows such testing for "positions affecting public safety."²⁹² While physicians must be mindful about the safety aspects of their job, they do not fall under this rubric. The EEOC's Office of Legal Counsel, writing to a city employer who wished to implement periodic medical examinations for its bus drivers, clarified that positions of public safety include police, firefighters, and private security officers who "pursue and detain fleeing criminal suspects."²⁹³ The letter noted further that while airline pilots are also among those where "public safety is integral to the job," their periodic testing is federally mandated.²⁹⁴ The EEOC said that city bus drivers are

291. 42 U.S.C. § 12112(b)(6) (2017).

292. EEOC Guidance, *supra* note 286, at B8 and C18.

293. EEOC Informal Discussion Letter on Americans with Disabilities Act: Periodic Testing (Feb. 15, 2008), https://www.eeoc.gov/eeoc/foia/letters/2008/ada_ltr_re_periodic_testing_feb_15_2008.html [hereinafter EEOC ADA Letter].

294. See 14 C.F.R. 61.121, 61.23 (2005). Federal law also requires periodic medical examinations for certain occupations where fitness-for-duty certificates are required. These include commercial truck drivers (49 C.F.R. §§ 39.41, 39.45 (2005)), marine pilots (46 C.F.R. § 10.709 (2005)), and hoist operators in open pit mines (30 C.F.R. § 56.19057 (2005)). For an in-depth discussion, see Jarod S. Gonzalez, *A Matter of Life and Death - Why the ADA Permits Mandatory Periodic Medical*

not in a position of public safety because “the magnitude of the potential harm resulting from a bus versus an airline accident makes the job of a city bus driver qualitatively different.” The EEOC explained:

[U]nlike the job of a police officer or firefighter, the job of a bus driver does not exist for the primary and specific purpose of protecting the general public from harm by *outside forces* and preventing significant injury and harm. Therefore, we do not believe that bus drivers fit squarely within the very *narrow definition of “positions affecting public safety”* as described in our guidance.²⁹⁵

Thus, any interpretation suggesting that that physicians are in a position affecting public safety is not supported by the statutory language of the ADA, the EEOC Enforcement Guidance,²⁹⁶ or EEOC correspondence. Only one federal law defines some physicians as public safety officers: physicians who serve as part of a public rescue squad or ambulance as defined by the Omnibus Crime Control and Safe Streets Act of 1968.²⁹⁷

Even if advocates for age-based testing of physicians were to succeed in arguing that physicians, as a group, should fall under the public safety exception, or that en masse screening for cognitive competency is justifiable under the business necessity clause, they would not be able to limit testing to older physicians. The ADA would require hospitals, like other employers allowed the

Examinations of “Remote-Location” Employees, 66 LA. L. REV. 681, 694-96 (2006).

295. Campbell, *supra* note 7 (emphasis added).

296. 29 C.F.R. app. § 1630(r) (2016).

297. 42 U.S.C. §10284(9) (2017) (defining “public safety officers” as public law enforcement officers, firefighters, chaplains, Federal Emergency Management Agency (FEMA) officials, or members of a rescue squad or ambulance crew who engage in rescue activity or in the provision of emergency medical services). These individuals are allowed specific tax benefits under the Pension Protection Act of 2006, Pub. L. No. 109-280, 120 Stat. 780. See also Department of Treasury, Publication 575: *Pension and Annuity Income* (2016).

business necessity defense, to administer the same "narrowly tailored" examinations "to address specific job-related concerns"²⁹⁸ to all physicians they employ without distinction by age.²⁹⁹ In other words, if hospitals hold verification of cognitive status essential to job preparedness and, as a result, argue that they should be exempt from requiring individualized reasonable belief or proving direct threat, they would need to screen not only those over sixty, sixty-five, or seventy, but in fact, all physicians on their staff, and with the same periodicity.

Some courts, however, have begun to expand the business necessity defense. In *EEOC v. Exxon Corp.*,³⁰⁰ the EEOC sued on behalf of a group of employees whose demotion was based on a disability even where the disability did not currently affect their ability to do their jobs.³⁰¹ After the chief officer of the vessel, a recovering alcoholic, was found to be legally drunk at the time of the Exxon Valdez disaster,³⁰² Exxon prohibited employees who received treatment for substance abuse from serving in certain "safety-sensitive, little-supervised

298.EEOC Guidance, *supra* note 286, at C18.

299.*Id.* (See Examples A-C).

300.EEOC v. Exxon Corp., 203 F.3d 871, 872 (5th Cir., 2000).

301.*Id.* ("[Exxon's] policy permanently removes any employee who has undergone treatment for substance abuse from certain safety-sensitive, little-supervised positions . . . pursuant to its policy, Exxon demoted employees who underwent treatment several decades ago."); see also, Press Release, EEOC, EEOC Sues Exxon for Disability Act Violation, Press Release (June 28, 1995). ("EEOC asserts . . . an employer must assess that person's current ability to safely perform the essential functions of his or her job . . . like all direct-threat determinations, it must be done through an individualized assessment based on medical analysis or other objective factual evidence. The determination cannot be based on subjective perceptions, irrational fears, patronizing attitudes, or stereotypes.").

302.David Lauter, *Legally Drunk Ship's Captain Fired by Exxon*, L.A. TIMES, Mar 31, 1989; AP, *A Question Recurs: Was Hazelwood Drunk?*, N.Y. TIMES (Feb 25, 1990), <http://www.nytimes.com/1990/02/25/us/a-question-recurs-was-hazelwood-drunk.html>.

positions.”³⁰³ The EEOC argued that Exxon violated the ADA because it failed to perform individualized assessments to prove that each employee affected by the company’s action posed a direct threat to public safety.³⁰⁴ Reversing the court below, the Fifth Circuit Court of Appeals held that the business necessity defense was not subject to the direct threat clause in cases where the employer established a safety-based qualification standard applicable to all employees of a class.³⁰⁵ The court further clarified that employers need not prove that an employee is a direct threat unless the employer had not established a qualification standard.³⁰⁶

The ADA protects employees with a past history of substance abuse,³⁰⁷ but not current substance abuse.³⁰⁸ In *Exxon*, the employer did not claim that

303.EEOC v. Exxon Corp., 203 F.3d. at 872.

304.*Id.* at 873 (quoting 29 U.S.C. § 12113).

305.*Id.* at 875. *Bates v. United Parcel Serv.*, 511 F.3d 993 (9thCir.2007) (“[W]hen an employer asserts a blanket safety-based qualification standard . . . and that qualification standard screens out or tends to screen out an individual with a disability, the employer . . . bears the burden of showing that the higher qualification standard is job-related and consistent with business necessity, and that performance cannot be achieved through reasonable accommodation. 42 U.S.C. § 12113(a).”).

306.Such a holding provides incentives to employers to proactively establish express qualification standards or to draft new policies after they have had to defend an employment action requiring proof of direct threat.

307.*See* 42 U.S.C. § 12114(b) (2017) (“Nothing in subsection (a) of this section shall be construed to exclude as a qualified individual with a disability an individual who (1) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use; (2) is participating in a supervised rehabilitation program and is no longer engaging in such use.”). *See Skinner v. City of Amsterdam*, 824 F. Supp. 2d 317, 330 (N.D. N.Y. 2010).

308.29 U.S.C. § 12114(a)(2017) (“For purposes of this subchapter, a qualified individual with a disability shall not include any employee or applicant who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.”).

it had evidence of current substance abuse for the employees it demoted. However, it argued that the employees could not meet its safety qualification standard based on the danger of recidivism in an unsupervised setting.³⁰⁹ On remanding the case to the lower court, the Fifth Circuit clarified that an employer cannot use the business necessity defense if it took an employment action based on "stereotypical assumptions."³¹⁰ To support a business necessity defense, a "real"³¹¹ risk assessment must occur that considers the duties of the employees' positions and the magnitude and probability of harm.³¹² The court emphasized that in this case, the "rate of recidivism"³¹³ was relevant to the risk assessment.

The *Exxon* court's expansive interpretation of the business necessity defense,³¹⁴ however, cannot support age-based testing of physicians for cognitive impairment as *Exxon's* unusual facts highlight the defense's inapplicability to the typical practice setting. First, all of the employees in *Exxon* were already identified as having a condition with a known high recidivism rate. This differs markedly from testing physicians without history and without cause. Allowing an employer to proactively bar high-risk employees from command provides no model for stereotyping age as a condition that warrants periodic medical examinations as a business necessity. Second, the

309. *EEOC v. Exxon Corp.*, 203 F.3d. at 872.

310. *Id.* at 875.

311. *Id.*

312. *Id.*

313. *Id.*

314. Other federal courts interpret the ADA's business necessity defense more restrictively, see, .e.g., *Bates v. United Parcel Serv.*, 511 F.3d 974, 996 (9th Cir.2007) ("The business necessity standard is quite high, and is not [to be] confused with mere expediency," quoting *Cripe v. San Jose*, 251 F.3d 877, 890 (9th Cir. 2001)); *Belk v. Southwestern Bell Tel. Co.*, 194 F.3d 946, 951 (8th Cir. 1999) (stating that employers must show that an exam administered to applicants is job-related based on the position's specific skills in order to prevail on a business necessity defense under the ADA).

Exxon employees would have been commanding in isolated, inaccessible settings where others could not prevent harm. Physicians in a hospital are typically under continual observation by other professionals, staff, and patients, and performance data are collected. Employers can require assessment of an individual employee when evidence raises a reasonable belief to justify doing so. Thus, categorizing periodic age-based cognitive screening of older physicians as a business necessity in the absence of cause violates the ADA.

The reasoning in *Exxon*, however, introduces the possibility that, without violating the ADA, an employer could proactively remove a physician from practice who has cognitive impairment. Even if current accommodations allow the physician to perform the essential functions of his job successfully,³¹⁵ if decline in the physician's condition is anticipated and the physician is likely to become unable to comply with safety qualification standards without warning, then under *Exxon*, business necessity should allow for proactive removal from practice. An employer could also defend removing a physician if the accommodation required for the physician to perform the essential functions of practice became too costly, like hiring a full-time clinician to shadow the physician. Once an accommodation becomes "unreasonable" or imposes an undue burden on the employer,³¹⁶ the employer need not continue providing it.

315.29 C.F.R. 1630.2 (n)(1) ("[E]ssential functions means the fundamental job duties of the employment position the individual with a disability holds or desires." Judging whether a job function is essential and not marginal may include: the position exists for the purpose of performing that function, very few people within the employment setting are available to perform that job function, or the hiree's expertise is what is required for the job.).

316.29 C.F.R. 1630.2(o)(4)(2016); 1630.2(p)(2016). Four examples of when an accommodation created an undue burden for an employer, see *Smith v. Frank Implement Co.*, 188 Fed.Appx. 549, 551 (8th Cir.2006); *Dropinski v. Douglas Cty.*, 298 F.3d 704, 706 (2002); *McDaniel v. AlliedSignal, Inc.*, 896 F.Supp. 1482, 1491 (1995); *Morrissey v. General Mills, Inc.*, 37 Fed. Appx. 842, 843-44 (8th Cir. 2002).

C. *Physician Employee Status for Purposes of the
ADEA and ADA*

As noted, the ADEA and the ADA protect the rights of "employees." However, neither the ADEA nor the ADA specify the scope of this term, as the nearly identical definitions offered under the ADEA ("an individual employed by any employer")³¹⁷ and the ADA ("an individual employed by an employer")³¹⁸ are both entirely circular.³¹⁹ The two statutes are clearly applicable where the hospital directly employs the physicians.³²⁰ The hospital hires and pays them, assigns and oversees their work, and can terminate them in accordance with their contract.³²¹ Other physicians may work within other practice structures, for example, a solo or partnership practice, a professional corporation, or an incorporated medical group.³²² Most also seek and are

317. 42 U.S.C. § 630(f) (2012).

318. 29 U.S.C. § 12111(4); 29 U.S.C. § 630(f) (2012). *See also* EEOC Compliance Manual, No. 915.003 §2: Threshold Issues 2-III(A)(1); *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323 (1992) (noting that the definition is circular). This definition is copied from the one in the Civil Rights Act of 1964, 42 U.S.C. 2000e(f), which is thus equally unhelpful.

319. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. at 323 (1992) (finding that an identical definition in ERISA is "completely circular and explains nothing.").

320. "Today, roughly 25 percent of all specialty physicians who see patients at hospitals" are employed directly by the hospital. For primary care physicians, the figure is 40 percent. Bob Herman, 7 *Trends in Hospital-Employed Physician Compensation*, BECKER'S HOSPITAL REVIEW (Jan. 25, 2013), <http://www.beckershospitalreview.com/compensation-issues/7-trends-in-hospital-employed-physician-compensation.html>; PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 446-47 (1984).

321. Alice G. Gosfield, *Negotiating Hospital Contracts: What Physicians Need to Know Before Signing*, MED. ECON. (Mar 24, 2014).

322. *See New Physician Practice Options: Choosing Your Practice Settings*, STAFF CARE (Jan. 21, 2016), <https://www.staffcare.com/physician-practice-options-choosing-your-practice-setting/>.

granted "hospital privileges"³²³ so they can care for patients who require inpatient or other hospital services. Privileges are tailored to the clinical competencies and training of each physician. Hospital privileges allow them to use hospital services,³²⁴ like nursing and support staff, laboratory services, operating rooms, procedure suites, equipment, and intensive care units, and to call upon other physicians with privileges, for consultation and referral.³²⁵

The question is whether physicians who structure their practice in ways other than direct employment by a hospital are "employees" for purposes of the ADEA and the ADA. The answer determines whether a hospital can require physicians with privileges to undergo age-based screening for cognitive impairment and take action against their privileges on the basis of test results without violating legal restrictions on employers described in the previous sections.

323. The granting of privileges imposes compliance duties on physicians, including following rules for admission physicals, writing orders, completing operative reports and discharge summaries. See, Letter from Thomas E. Hamilton, Director, Centers for Medicare & Medicaid Services (CMS), to State Survey Agency Director (Nov. 12, 2004), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-04.pdf>. See also Craig W. Dallan, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 607-08 (2000)

324. See, e.g., *Salamon v. Our Lady of Victory Hospital*, 514 F.3d 217, 222 (2nd Cir. 2008).

325. See Andrew K. Dolan & Richard S. Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 709-23 (1980) (providing a general description of admitting privileges arrangements); Jeffrey E. Harris, *The Internal Organization of Hospitals: Some Economic Implications*, 8 BELL J. ECON. 467, 470 (1977) (stating that hospitals organize as separate firms, with a demand division consisting of the administration and a supply division consisting of the physicians); Philip C. Kissam, *Antitrust and Hospital Privileges*, 70 CAL. L. REV. 595, 603-13 (1982) (providing a description of formal, political and economic features of admitting privileges in antitrust context).

This question is complicated because of the way that practice structure varies and the way that hospitals staff clinical services. The hospital's medical staff may include physicians from a combination of practice settings, or it might primarily include physicians practicing within a large multispecialty medical group providing virtually all of the hospital's services, for example, within academic medical centers³²⁶ or large "staff model" health maintenance organizations.³²⁷ Hospitals also commonly contract with single specialty medical groups to provide coverage for specific services, such as anesthesia, emergency, diagnostic imaging, and hospitalist care.³²⁸ These practice and financial arrangements for the provision of health care, a matter of great public controversy in recent years,³²⁹ continue to evolve.

Given this profusion of business and professional relationships, it is essential to discern some underlying principles to resolve questions about a physician's employment status. In the typical common law employment situation, a single entity would exercise both fiscal and managerial control over the

326. See Thomas Enders & Joanne Conroy, *Advancing the Academic Health System for the Future, A Report from the AAMC Advisory Panel on Health Care 1, 9* (2014). (discussing that successful academic medical centers will align hospitals, clinical faculty, medical school, management accountability, and enterprise-level structure).

327. See Jesse Pines et al., *Kaiser Permanente—California: A Model for Integrated Care for the Ill and Injured*, THE BROOKINGS INST. 1, 3 (May 4, 2015) (discussing that all Kaiser Foundation Hospitals are staffed through an exclusive contract with Permanente Medical Group).

328. A hospitalist is an internal medicine or pediatric specialist whose practice is dedicated to taking care of hospital inpatients. Bonnie Darves, *Locked Out: Why Some Hospitals Are Limiting Which Hospitalists Can Work on Their Wards*, TODAY'S HOSPITALIST (Oct. 2004), <https://www.todayshospitalist.com/locked-out-why-some-hospitals-are-limiting-which-hospitalists-can-work-on-their-wards/>.

329. C. Stephen Redhead & Janet Kinzer, *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act*, CONGRESSIONAL RES. SERV. (Feb. 7, 2017), available at <https://fas.org/sgp/crs/misc/R43289.pdf>.

employee.³³⁰ That is, this entity—the employer—would both pay and supervise the employee, with these two modes of control connected to each other. A feature of the admitting privileges structure is to disaggregate these functions, with the physician's practice, corporation, or medical group generally exercising fiscal control over physician billing while the hospital maintains significant managerial authority³³¹ over the services that are provided within its facilities. Thus, a physician may be considered an independent contractor for financial purposes,³³² and simultaneously regarded as an employee of the hospital for other purposes, especially practice-related issues within the hospital.³³³ Hospitals exert control over physicians through their power to set rules and policies affecting medical practice.³³⁴ All physicians who wish to perform procedures and order tests, for example, are subject to the same rules regarding timing and availability of hospital facilities and

330. See 20 C.F.R. § 404.1007 - Common-law employee.

331. See Robert C. Post, *Between Governance and Management: The History and Theory of the Public Forum*, 34 UCLA L. REV. 1713, 1717 (1987). Managerial authority pertains to the actions taken by an entity to "administer organizational domains dedicated to instrumental conduct."

332. See Leon S. Conlon, *Peer Review and Public Policy*, 19 Loy. U. CHI. L.J. 1237, 1237 (1988); see generally, Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Admitting Privileges Considered Employees under Title VII or the ADA Act When Alleging an Employment Discrimination Claim?*, 1 DEPAUL J. HEALTH CARE L. 119 (1996).

333. See, e.g., *Insinga v. LaBella*, 543 So.2d 209, 213 (Fla. 1989); *Pedroza v. Bryant*, 101 Wash.2d 226, 229 (Wash., 1984) (en banc).

334. See Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. L. REV. 455, 500 (2013) (The hospital's culture exerts control over how physicians "process and analyze information," and they internalize its "values and norms." Physicians tend to trust internal colleagues more than colleagues outside of the organization and practice in accordance with how things are done within the organization. *Id.* at 504-505.).

equipment, performing "time-outs,"³³⁵ and following infection control policies such as those related to hand hygiene³³⁶ and universal precautions.³³⁷ Hospitals also generally delegate portions of their duties to an organized medical staff,³³⁸ especially in regards to credentialing, privileging, and monitoring clinician performance.³³⁹ The medical

335. See Nancy M. Saufl, *Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery*, 19 J. PERIANESTHESIA NURSING 348, 349-50 (2004). The time-out procedure is designed to reduce the risk of error in the operating room. The team confers just before the surgery starts as a last chance to make certain that the patient is the right patient, the procedure they are about to do is the correct procedure on the correct site on the body, and that all needed equipment and implants are present in the operating room.

336. See Thomas R. Talbot et al., *Sustained Improvement in Hand Hygiene Adherence: Utilizing Shared Accountability And Financial Incentives*, 34 INFECTION CONTROL & HOSP. EPIDEMIOLOGY 1129, 1134-35 (2013).

337. Universal precautions are utilized in all cases where contact with blood or body fluids is possible to prevent the transmission of bloodborne pathogens. Healthcare workers don appropriate protective barriers (e.g., masks, gloves, gowns, and/or goggles) to prevent exposure. See Centers for Disease Control and Prevention, *Perspectives in Disease Prevention and Health Promotion Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings*, 37 MORBIDITY & MORTALITY WKLY REP. (1988), available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/00000039.htm>.

338. See e.g. 42 C.F.R. § 482.12 (a) (2-5) (2016); THE JOINT COMMISSION COMPREHENSIVE ACCREDITATION & CERTIFICATION MANUAL at LD.01.05.01 (2018) ("The . . . hospital has an organized medical staff that is accountable to the governing body.") [hereinafter TJC Standards].

339. See TJC Standards at MS.03.01.01 ("The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.").

staff is at once both its own entity³⁴⁰ and subsidiary to and part of the larger enterprise.³⁴¹

Before 2003, federal courts used two competing standards to determine what "employer" meant in federal statutes that did not include a true definition. The older standard, re-stated in *United States v. Silk*,³⁴² was based upon the common law principle that employment status depended on the degree of control a company exercised over an individual.³⁴³ Shortly after that decision, however, the court articulated an alternative test in *Bartels*

340. Courts have differing views as to whether the medical staff is a legal entity. Some find it to be an independent legal entity. See Sheryl Tatar Dacso & Robert Bennett, *Is There A Case for an Independent Medical Staff*, LEGAL TALK (Jan. 2007), http://bennettlawfirm.typepad.com/the_bennett_law_firm/files/independent_medical_staff.pdf (discussing a California Superior Court ruling which determined that a hospital's Medical Staff was an independent legal entity that could be sued). Others characterize it as an unincorporated association. See *Avera Marshall Med. Staff v. Avera Marshall*, 857 N.W.2d 695, 700 (Minn. 2014); *Corleto v. Shore Mem'l Hosp.*, 350 A.2d 531, 539 (N.J. Super. Ct. Law Div. 1975). Still, others view it as a subordinate to the hospital (see, e.g., *Exeter Hospital Medical Staff v. Board of Trustees*, 810 A.2d 53, 56-57 (N.H. 2002) ("[T]he medical staff in this case is not a legal entity separate and apart from the hospital, but rather is a subordinate administrative unit dependent upon and accountable to the hospital . . . [t]he medical staff has no legal life of its own and is merely one component of the hospital corporation.")).

341. See Alice G. Gosfield, *Whither Medical Staffs?: Rethinking the Role of the Staff in the New Quality Era*, In: HEALTH L. HANDBOOK 141, 145 (2003) ("The clinical culture of the hospital is broader than the medical staff culture, and in the last analysis, is the reflection of the extent to which the operations and attention of the institution are focused around and supportive of ever improving clinical quality of care in all of the broader reaches of current definitions of quality.").

342. *U.S. v. Silk*, 331 U.S. 704, 717-18 (1947) (determining whether the company or the individual is liable for Social Security taxes).

343. *Id.* at 714-15.

v. Birmingham,³⁴⁴ which focused on the “economic realities” of the relationship between the parties.³⁴⁵ In *Spirides v. Reinhardt*, a sex discrimination case brought under Title VII of the Civil Rights Act,³⁴⁶ the court elaborated upon this test.³⁴⁷ The *Spirides* court identified eleven factors relevant to determining whether a plaintiff was an employee for purposes of Title VII.³⁴⁸ Several courts then used the *Spirides* factors to determine whether doctors with admitting privileges were employees under the ADEA.³⁴⁹

In 2003, the United States Supreme Court reviewed the meaning of the term “employee” in *Clackamas*

344. *Bartels v. Birmingham*, 332 U.S. 126, 130 (1947) (determining whether the company or the individual is liable for Social Security taxes).

345. *Id.* at 831-32.

346. *Spirides v. Reinhardt*, 613 F.2d 826, 828 (D.C. Cir. 1979).

347. *Id.*

348. *Id.* (The Court articulated these factors as follows: “(1) the kind of occupation, with reference to whether the work usually is done under the direction of a supervisor or is done by a specialist without supervision; (2) the skill required in the particular occupation; (3) whether the ‘employer’ or the individual in question furnishes the equipment used and the place of work; (4) the length of time during which the individual has worked; (5) the method of payment, whether by time or by the job; (6) the manner in which the work relationship is terminated; *i.e.*, by one or both parties, with or without notice and explanation; (7) whether annual leave is afforded; (8) whether the work is an integral part of the business of the ‘employer’; (9) whether the worker accumulates retirement benefits; (10) whether the ‘employer’ pays social security taxes; and (11) the intention of the parties.”).

349. *Diggs v. Harris Hospital-Methodist, Inc.*, 847 F.2d 270, 272-73 (5th Cir. 1988), 488 U.S. 956 (*cert. denied*); *Mallare v. St. Luke’s Hosp.*, 699 F. Supp. 1127, 1129-30 (E.D. Pa. 1988) *affd*, 914 F.2d 243 (3d Cir 1990) (relying on *EEOC v. Zippo Manufacturing Co.*, 713 F. 2d 32 (3rd Cir., 1983), which relied on *Spirides* at 37). *See also Mitchell v. Frank R. Howard Memorial Hospital*, 853 F.2d 762, 766 (9th Cir. 1988), *cert. denied*, 489 U.S. 1013 (1989) (holding that the test depends on “economic realities”).

Gastroenterology Assoc., P.C. v. Wells, an ADA case. The question concerned the employment status of physicians in a professional corporation rather than their status in a hospital.³⁵⁰ The professional corporation in *Clackamas* moved to dismiss a former employee's suit arguing that because the physicians in the corporation, as shareholder-directors, did not count as employees, the corporation had too few employees for the ADA to apply.³⁵¹

Despite the difference in practice setting, the test that the Court used is relevant to ADEA and ADA suits against a hospital. Writing for the Court, Justice Stevens returned to the common law control test.³⁵² He conceded that the mode of doing business at issue in the case, as a professional corporation, was unknown at common law but nonetheless held that common law principles should control the determination.³⁵³ He then continued: "[a]t common law the relevant factors defining the master-servant relationship focus on the master's control over the servant . . . We think that the common-law element of control is the principal guidepost that should be followed in this case."³⁵⁴ Justice Stevens stated that this conclusion was supported by a compliance manual issued by the EEOC, the agency charged with implementing the ADA, which identified the crucial issue as "whether the employer controls the means and manner of the worker's work performance."³⁵⁵ While the language did not appear in an agency rule entitled to *Chevron* deference, the Court held that it was entitled to the *Skidmore* deference³⁵⁶ and

350. *Clackamas Gastroenterology Assoc. v. Wells* 538 U.S. 440, 442 (2003).

351. *Id.* at 442.

352. *Id.* at 444-46.

353. *Id.* at 447-48.

354. *Id.* at 448.

355. *Id.* at 449 (quoting EEOC Compliance Manual § 605:0008, and n. 71.8).

356. *Id.* at 449-50. (The interpretation of a statute in a definitive legal determination (such as regulations promulgated by notice and comment rule-making or a formal adjudication) by the agency charged by Congress with implementing a statute is granted deference under *Chevron USA, Inc. v. NRDC*, 467 U.S. 837 (1984). This

proceeded to quote the compliance manual's list of six relevant factors³⁵⁷ for determining the extent to which the physicians exercised control over the organization. The Court then remanded the case with the instruction to examine all aspects of the employment relationship for "evidence in the record that would . . . support a contrary conclusion."³⁵⁸

The *Clackamas* Court's choice of common law to determine the meaning of the term "employee" was based on Congressional intent.³⁵⁹ In leaving the term

means that the reviewing court should defer to any reasonable interpretation of the law by the agency when the term being interpreted is ambiguous. It reverses the traditional rule that a reviewing court defers to a trial court on issues of fact but reviews interpretations of law de novo. If the interpretation is embodied in a less definitive pronouncement by the agency, such as an ad hoc decision, guidance or compliance manual, it does not receive this level of deference, but may nonetheless be regarded as "a body of experience and informed judgment" that courts can look to for guidance); *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944), see, *U.S. v. Mead Corp.*, 533 U.S. 218 (2001) (establishing the boundary between *Chevron* and *Skidmore* deference)).

357. *Id.*, citing EEOC, Compliance Manual § 605:0009 (2000) (enumerating six factors that help in determining whether physicians are employees or proprietors: "[w]hether the organization can hire or fire the individual or set the rules and regulations of the individual's work . . . Whether and, if so, to what extent the organization supervises the individual's work . . . Whether the individual reports to someone higher in the organization . . . Whether and, if so, to what extent the individual is able to influence the organization . . . Whether the parties intended that the individual be an employee, as expressed in written agreements or contracts . . . Whether the individual shares in the profits, losses, and liabilities of the organization.").

358. *Id.* at 451.

359. *Id.* at 445 ("When Congress has used the term "employee" without defining it, we have concluded that Congress intended to describe the conventional master-servant relationship as understood by common-law agency doctrine." citing *Darden*, 503 U.S. at 322-23.) Justice Stevens went on to say: "as *Darden* reminds us, congressional silence often reflects an expectation that courts will look to the common law to fill gaps in statutory text, particularly when an undefined term has a settled meaning at common law. Congress has overridden judicial decisions that went beyond the common law in an

open-ended, the Court reasoned, Congress expected both agency and judicial interpreters to rely on the meaning of the term as interpreted at common law.³⁶⁰

While the *Clackamas* Court utilized this more linguistic analysis based on the common law meaning of the term "employee" and avoided an analysis based on the broad purpose of the statutes,³⁶¹ courts must consider statutory purpose when applying common law meaning to novel situations such as the one the medical profession presents.³⁶² Federal anti-discrimination statutes aim to prevent discrimination based on a protected characteristic: the ADEA prohibits discrimination based on age, and the ADA prohibits discrimination based on disability. The crucial question then is to determine which entity exercises the control that would place it in a position to potentially engage in these forbidden forms of discrimination. That entity should be regarded as the "employer" for purposes of imposing the two Acts' regulatory restrictions.

The answer depends on the relationship between the hospital and the physicians with clinical privileges.³⁶³ If physicians—whether individual or as part of an affiliated medical group—admit patients to only one hospital and depend on those admissions to maintain their practice,³⁶⁴ then the hospital's managerial authority enables the hospital to discriminate against these physicians on the basis of age or disability. Specifically, the hospital could require physicians to submit to cognitive testing without any evidence of impaired performance, and then revoke their privileges,

effort to correct "the mischief' at which a statute was aimed." *Clackamas*, 538 U.S. at 447.

360.*Id.* at 447.

361.*Id.* at 446 ("The majority's approach, which paid particular attention to 'the broad purpose of the ADA'" does not "fare any better.").

362.*See* Kevin Stack, *Interpreting Regulations*, 111 MICH. L. REV. 355 (2012) (observing and arguing for judicial use of purposivism to interpret administrative regulations).

363.*See* Conlon, *supra* note 332, at 160.

364.*Id.*

denying them access to its facilities and thereby destroying their practice, if they refused to comply. The hospital's ability to discriminate in this manner means it is exercising control over physicians consistent with the common law meaning of the term.³⁶⁵

However, an employment relationship is two-sided. Physicians who rarely use their admitting privileges resemble independent contractors rather than employees and thus would occupy the sort of position that Congress intended to exclude from the ADEA and ADA's coverage. Physicians would also look less like employees in the intermediate situation where they actively admit to more than one hospital. Although the governing principle is the same, resolving each situation will depend on the circumstances of each particular case. The principle is whether the hospital charged with age discrimination exercised a sufficient managerial role to constitute control within the common law meaning of that term, and therefore, was the plaintiff's employer for purposes of the ADEA and ADA. Relevant facts to determine when control is sufficient include the centrality of using the hospital as part of one's practice, the number of hospitals to which the physician admits or to which she could admit,³⁶⁶ and the presence of any collusive behavior among the hospitals. If hospitals were to collude to impose age-based cognitive screening, it would deprive the admitting physicians of their apparent choice because they would be facing the same rule in all hospitals in a given area.

As with the substance of a BFOQ, excluding hospitals from the status of an employer should be narrowly construed to effectuate the purposes of the ADEA and the ADA. Specifically, the defendant-hospital's argument that they are able to impose cognitive testing on physicians who are members of a separate fiscal entity and take action on the

365. *Id.*

366. *Diggs v. Harris Hosp. Methodist, Inc.*, 847 F.2d 270, 273 ("[N]o evidence submitted . . . that denial of staff privileges at Harris Hospital hampered her ability to obtain staff privileges at any other Fort Worth hospital.").

results of such testing because these physicians are free to get privileges from other hospitals must be viewed with suspicion. Such an argument, after all, can be made in any employment case where the employer is not a monopolist. The practical reasons to reject it are that establishing privileges at a new hospital will cause a hiatus in income, involve considerable inconvenience, and may constitute a loss of status.

Beyond that, however, is a more basic issue: the essence of any statute forbidding discrimination in employment that imposes additional requirements based only on the employee's protected trait is discrimination, and thus illegal per se, whatever its practical consequences may be. Even a person who can find a better position after he has been fired on the basis of race, religion or gender is nonetheless the victim of discrimination. The same is true for age.

Thus, the EEOC factors, as endorsed in *Clackamas*,³⁶⁷ strongly support this understanding of managerial control. Because hospitals impose rules and oversight over physicians and hold them accountable, they, in effect, exercise such control. That level of control continues to increase today.³⁶⁸ A variety of legal, economic, and regulatory factors further incentivize or mandate hospitals to take active roles in monitoring and addressing physician behavior and performance irrespective of whether the physicians are directly employed or employed by a fiscally independent entity. These include:

367. See *Clackamas*, 538 U.S. at 449.

368. See generally William B. Drummy III, *The Hospital and Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249 (1974); Daniel M. Mulholland III, *The Corporate Responsibility of the Community Hospital*, 17 U. TOL. L. REV. 343, 367 (1986); Christine A. Goeschel et al., *Responsibility for Quality Improvement and Patient Safety*, 138 CHEST 171, 172 (2010); Arianne N. Callendar, Douglas A. Hastings, Michael C. Helmsley, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*, OFFICE OF THE INSPECTOR GENERAL (June 2007), <https://psnet.ahrq.gov/resources/resource/5601/corporate-responsibility-and-health-care-quality-a-resource-for-health-care-boards-of-directors>.

(1) *Evolving common law doctrine.* The *Clackamas* Court's invocation of common law doctrine as the background for the federal law meaning of "employee" illustrates how the common law evolves over time.³⁶⁹ The trend in cases involving corporate negligence and enterprise liability doctrines is to place liability on hospitals and health systems because they are in the best position to ensure patient safety. According to the seminal case on corporate negligence, *Darling v. Charleston Community Memorial Hospital*:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment.³⁷⁰

Enterprise liability aims to encourage integration of professionals, systems, services, and practices into a structure that can exert more uniform control and supervision over processes, behavior, and performance to prevent future injury.³⁷¹ Its contemporary interpretation reflects

369. See Eisenberg, *supra* note 253.

370. *Darling v. Charleston Community Memorial Hosp*, 211 N.E.2d 253, 257 (1965) (citation omitted) (stating that, under the corporate negligence doctrine, hospitals may be held directly liable to patients for failing to adequately assess the competence of healthcare professionals.). See also, Mitchell J. Wiet, *Darling v. Charleston Community Memorial Hospital and Its Legacy*, 14 ANNALS HEALTH L. 399, 408 (2005). ("Darling has . . . helped to bring about a quantum leap improvement over time in the quality of health care in the United States. That is a very good thing, indeed, for all health care consumers.").

371. William M. Sage, *Enterprise Liability and The Emerging Managed Health Care System*, 60 L. CONTEMPORARY PROBS, 159, 163 (1997). See also, Mantel, *supra* note 334, at 516-17 (because organizational culture influences medical decision-making, imposing enterprise liability on the managerial control of healthcare organizations will reduce medical error).

" . . . a system in which health care organizations bear responsibility for medical malpractice in addition to or instead of individual health professionals."³⁷²

(2) *Private regulation.*³⁷³ The Joint Commission (TJC) is a private organization that accredits hospitals meeting its compliance standards. Accreditation by TJC is widely accepted as an assurance of quality.³⁷⁴ TJC standards charge hospitals' governing boards with oversight responsibility for the care provided within the institution,³⁷⁵ holding the medical staff accountable,³⁷⁶ and addressing behaviors that undermine a culture of safety.³⁷⁷ TJC also holds

372. *Id.* at 159. See also William R. Trail & Susan Kelley-Claybrook, *Hospital Liability and the Staff Privileges Dilemma*, 37 BAYLOR L. REV. 315, 329 (1985); Drummy, *supra* note 368; James B. Cohoon, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383 (1980).

373. See Robert D. Cooter, *Decentralized Law for a Complex Economy: The Structural Approach to Adjudicating the New Law Merchant*, 144 U. PA. L. REV. 1643, 1649-50 (1996) (explaining how norms generated within civil society become informally codified by private institutions and serve as standards, and also incorporated into the legal system by serving as sources of common law decisions or templates for positive enactments by statute or regulation).

374. See Dallan, *supra* note 323, at 603 (stating "[t]he influence of JCAHO [now The Joint Commission] accreditation requirements, including those governing medical staffs, is considerable" and most hospitals seek such accreditation); Stephen P. Schmaltz et al., *Hospital Performance Trends on National Quality Measures and the Association with Joint Commission Accreditation*, 6 J. HOSP. MED. 454, 454 (2011) (finding that accredited hospitals outperform those without accreditation with the gap widening over time).

375. Goeschel, *supra* note 368, at 172. See also, TJC Standards at LD.01.03.01 ("The governing body is ultimately accountable for the safety and quality of care, treatment, and services.").

376. TJC Standards at LD.01.05.01 ("The hospital has an organized medical staff that is accountable to the governing body.").

377. See *Behaviors That Undermine a Culture of Safety*, THE JOINT COMMISSION, (Sentinel Event Alert #40), July 9, 2008.

hospitals accountable for having "a clearly defined process for collecting, investigation, and addressing clinical practice concerns."³⁷⁸

(3) *Public regulation.* Hospitals must satisfy the Centers for Medicare and Medicaid Services' ("CMS") Conditions of Participation to be eligible for reimbursement.³⁷⁹ CMS holds the governing body accountable for the hospital's conduct,³⁸⁰ quality of patient care, and competency of its credentialed medical staff.³⁸¹ CMS also expects the hospital to deliver patient-centered care³⁸² and to establish a complaint and grievance resolution process to address and respond to patients' concerns about quality of care,³⁸³ including complaints about

[hereinafter SEA #40]. See also TJC Standards at LD.03.01.01.

378. TJC Standards at MS.09.01.01.01.

379. See Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation 42 C.F.R. Part 482 and 485 (2016).

380. 42 C. F. R. § 482.12 (2016).

381. 42 C.F.R. 482.12(a) (2016); See Gosfield, *supra* note 321, at 148; Centers for Medicare & Medicaid Services (CMS) Requirements for Hospital Medical Staff Privileging (Nov. 12, 2004) ("Components of . . . qualifications and demonstrated competencies would include at least: current work practice, special training, quality of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, . . . currency of . . . licensure requirement . . .").

382. Gosfield, *supra* note 321, at 146. See also Jordan M. VanLare & Patrick Conway, *Value-based Purchasing—National Programs To Move From Volume To Value*, 367 NEW ENGL. J. MED. 292, 293 (2012). CMS performs random sampling of hospital patients to learn of their experiences of care, utilizing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. CMS withholds 1% of Medicare payments, 30% of which is tied to HCAHPS scores, to fund incentives of the ACA's Hospital Value-Based Purchasing program; see Shivan Mehta, *Patient Satisfaction Reporting and Its Implications for Patient Care*, 17 AMA J. OF ETHICS 616, 617 (2015).

383. See 42 C.F.R. § 482.13(a)(2) (2016) ("The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.").

physicians. The Healthcare Quality Improvement Act of 1986 (HCQIA), which sets due process procedural standards for taking action against physicians' clinical privileges,³⁸⁴ also requires hospitals to report such actions and medical malpractice payouts to the National Practitioner Database ("NPDB"). Hospitals must also query the NPDB whenever a physician applies for medical staff membership and clinical privileges.³⁸⁵

As these forces operate to expand the managerial control that hospitals exercise, including their obligation to oversee the quality of care provided by physicians with admitting privileges, the increased control also elevates the importance of ensuring that hospitals do not rely on legally prohibited criteria to impose burdens on physicians or make determinations about privileges. Thus, a physician with a qualified disability, including a perceived disability, could argue that the hospital used "methods of administration that have the effect of discrimination on the basis of disability, or that perpetuate the discrimination of others who are subject to common administrative control."³⁸⁶ Thus, the term "employee" in the ADEA and the ADA should

384. See generally Healthcare Quality Improvement Act of 1986 (HCQIA) 42 U.S.C. § 11011 *et seq.* (sets due process standards for peer review and actions against clinical privileges). HCQIA also requires insurance companies to report medical malpractice payments, state medical boards to report sanctions, and hospitals to report adverse actions against clinical privileges to the National Practitioner Data Bank (NPDB). See also *Health Care Quality Improvement Act of 1986*, THE AMERICAN HEALTH LAWYERS ASS'N, <https://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/HCQIA.aspx> (last visited Apr. 9, 2018). For specified actions that require a report to relevant agency; timeliness and contents; confidentiality; liability' fine for failure to make or transmit report, see, e.g., Cal. Bus. & Prof. Code § 805 (reporting requirements for peer review bodies).

385. 42 U.S.C. §§ 11131-33 (2017); U.S. Dept. of Health and Human Services. *National Practitioner Data Bank, Chapter D: Queries.* <https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp?page=DOverview.jsp> (last visited Jan. 14. 2018).

386. 42 U.S. Code § 12112(b) (3) (2017).

include physicians with clinical privileges whom the hospital does not directly employ.

Further, the differences between fiscal and managerial control favor treating managerial control as the guiding factor.³⁸⁷ Relinquishing managerial control over physicians who use hospital facilities would require a major change in the hospital's operations, a change it would not likely choose. Fiscal control, on the other hand, is malleable. Drafting a new set of documents can alter the corporate form that pays physicians or how it disburses their compensation and benefits. To give equal or greater weight to fiscal control in determining a physician's status as an employee would enable a hospital to circumvent the requirements of anti-discrimination statutes without significantly affecting the hospital's operations.

In many cases, the organized medical staff would likely play a significant role in implementing an age-based screening policy. As a non-employer, the medical staff could do this without violating the ADEA or ADA. However, because accreditation standards for hospitals require, first, that the governing body and hospital approve the medical staff by-laws³⁸⁸ and, second, that the governing body and medical staff collaborate in monitoring physician qualifications and quality of care,³⁸⁹ any age-based testing policy implemented by the medical staff is also a policy of the hospital.

387. See Lowe, *supra* note 332, at 126 (citing Title I of the ADA section 12112(b)(3)).

388. TJC Standards at MS.01.01.01.02 See also 42 C.F.R. § 482.12(a) (4) (2016) ("The governing body must[. . .](4) Approve medical staff bylaws and other medical staff rules and regulations.").

389. See e.g., TJC Standards at MS.01.01.01 and LD.01.05.01.06 (medical staff is accountable to the governing body), MS.06.01.03.02 and MS.06.01.03.03 (the medical staff and hospital are jointly involved in the credentialing process); MS.06.01.11 (governing is involved in decisions related to initial privileging and appointment); LD.01.03.01 (the governing body is ultimately accountable for the safety and quality of care, treatment, and services).

Finally, the ADA's protections are not limited to employees. Title III of the statute states: "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of . . . privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."³⁹⁰ In *Menkowitz v. Pottstown Memorial Medical Center*, the Third Circuit Court of Appeals found that a hospital violated Title III by denying staff privileges to a physician with a disability that his psychologist certified would not impair his ability to treat patients and work with others.³⁹¹ The court found that although the plaintiff-physician was not an employee of the hospital, he was an "individual" under Title III of the ADA.³⁹² Rejecting the hospital's argument that Title III applied only to members of the public receiving service from the hospital, the court said: "[b]ecause of the appellant's suspension from the active medical staff, he can no longer enjoy the hospital's physical facilities in providing the necessary medical and consulting services to his patients."³⁹³ Thus, even if non-directly employed physicians are not "employees" of the hospital, should a hospital require age-based testing of all older physicians who work there, it would deprive these older physicians of equal enjoyment of privileges and advantages.

IV. Alternative Models for Identifying and Responding to Suspected Cognitive Impairment

The rejection of age-based screening for cognitive impairment, on the grounds it is a poor pragmatic strategy and a legally discriminatory approach under the ADEA and the ADA, does not leave

390. 42 U.S.C. § 12182(a) (2017).

391. *Menkowitz v. Pottstown Memorial Med. Ctr.*, 154 F.3d 113, 122 (3d Cir. 1998).

392. *See also*, *Haas v. Wyoming Valley Health Care System*, 553 F. Supp. 2d 390, 396 (M.D. Pa. 2008) (a physician "does have standing to bring a claim pursuant to Title III of the ADA").

393. *Menkowitz*, 154 F.3d at 122.

hospitals powerless to act in securing patient safety. In its place, they must instead develop methodologies to assist in detecting compromised physicians, irrespective of age. Furthermore, taking action when medical professionals exhibit outlier behavior or performance, whatever its cause, falls within the authority of healthcare leaders. Leaders and organizations should thus strive to reliably identify and address physicians who pose risk to patients but not interfere with physicians who do not demonstrate cause for concern.

A comprehensive and effective strategy for dealing with the problem of cognitive impairment among physicians involves three basic elements. First, there must be reliable and non-discriminatory methods for detecting performance and behavior-related problems. Second, the organization must institute administrative measures to ensure proper and effective implementation of the detection system. Third, there must be a mechanism for dealing with the results of the detection process. This entails taking humane but expeditious action to remove dysfunctional physicians from caring for patients, and prompt determination and institution of reasonable accommodations for those who, with such accommodations, could practice safely. This Part IV will begin by briefly surveying the existing standards for addressing cognitive impairment followed by suggestions for strengthening implementation.

*A. Existing Standards for Addressing Physicians with
Behavior and/or Performance Issues*

1. Ethical Duties

Physicians cannot serve patients as well as they might if they do not address their own and their colleagues' human failings. Those who practice medicine as a profession are ethically bound to practice professional self-regulation, that is to say, conscientious self-monitoring and group regulation.³⁹⁴ Self-monitoring includes recognizing

394. See Sylvia R. Cruess et al., "Profession": A Working Definition for Medical Educators, 16 *TEACHING & LEARNING MED.* 74, 75 (2004) ("members are governed by codes of ethics and profess a commitment to competence, integrity

the limits of one's expertise, maintaining awareness of how one's own behavior and performance impacts others, and being willing to receive feedback.³⁹⁵ Professional group regulation requires similar engagement with colleagues, including participation in peer review activities³⁹⁶ and taking action to safeguard patients when colleagues fail to provide appropriate medical care or self-correct after feedback.³⁹⁷

Physicians are not always successful at complying with the ethical duty to self-monitor.³⁹⁸ One reason may be that they are reluctant to make use of medical services.³⁹⁹ Less than half of practicing physicians have their own physician, and they underutilize physician services,⁴⁰⁰ which may contribute to delayed recognition of conditions affecting their

and morality, altruism, and the promotion of the public good . . . [S]ociety . . . in return grants the profession . . . the privilege of self-regulation. Professions and their members are accountable to those served and to society."); Louise Arnold, *Assessing Professional Behavior: Yesterday, Today, and Tomorrow*, 77 ACAD. MED. 502, 504 (2002) (finding that "[a]lthough autonomy and self-regulation may be passé due to the encroaching role of agencies external to medicine . . . these elements are more critical than ever if medicine is to remain a profession.").

395. Gerald B. Hickson & Ilene N. Moore, *Professional Accountability and Pursuit of a Culture Of Safety*, in PEDIATRIC SAFETY & QUALITY IMPROVEMENT 239, 241 (Karen S. Frush & Steven E. Krug, eds. 2014).

396. Moore et al, *supra* note 57, at 1177-78.

397. Lynn E. Webb et al., *Using Coworker Observations To Promote Accountability For Disrespectful And Unsafe Behaviors By Physicians And Advanced Practice Professionals*, 42 JOINT COMMISSION J. QUALITY PATIENT SAFETY 149, 150, 152 (2016).

398. See, e.g., Physician Health & Wellness, AMA Council on Ethical and Jud. Aff. Op. 9.3.1 (2016) (stating that "physicians have a responsibility to maintain their health and wellness . . . preventing or treating . . . diseases, including mental illness, disabilities, and occupational stress."); John Harrison, *Doctors' Health and Fitness to Practise: Assessment Models*, 58 OCCUPATIONAL MED. 318, 318 (2008).

399. Harrison, *supra* note 398, at 318.

400. *Id.*

ability to practice safely.⁴⁰¹ Cognitive impairment and other illnesses can further affect judgment and the ability to self-monitor.⁴⁰²

Reporting colleagues perceived as impaired is also fraught with difficulties. Even when professionals are aware of the ethical duty to report impaired or incompetent colleagues⁴⁰³ and have direct personal knowledge of an impaired colleague, one third to one half of physicians choose not to do so.⁴⁰⁴ The reasons why include believing that someone else already made a report; expecting that nothing would be done even if the report were made; unawareness of how to report; and concern that the reporting physician would suffer retaliation.⁴⁰⁵

The American Medical Association (AMA) Council on Ethical and Judicial Affairs has issued two Opinions⁴⁰⁶ pertaining to reporting colleagues. Opinion 9.4.2, Reporting Incompetent or Unethical Behavior by Colleagues states that:

Physicians who *become aware or strongly suspect* that conduct threatens patient welfare . . . should . . . [r]eport the conduct to appropriate clinical authorities . . . include notifying the peer review body of the hospital, or the local or state medical society when the physician of concern does not have hospital privileges . . . [r]eport directly to the state

401. *Id.*

402. Asmus Vogel et al., *Awareness of Deficits in Mild Cognitive Impairment and Alzheimer's Disease: Do MCI Patients Have Impaired Insight?*, 17 *DEMENTIA & GERIATRIC COGNITIVE DISORDERS* 181, 181 (2004).

403. *Physician Health & Wellness*, AMA Council on Ethical and Jud. Aff. Op. 9.3.2 (2016); *Physician Health & Wellness*, AMA Council on Ethical and Jud. Aff. Op. 9.4.2 (2016).

404. DesRoches et al., *supra* note 7, at 187; Eric G. Campbell et al., *Professionalism in Medicine: Results of a National Survey of Physicians*, 147 *ANNALS INTERNAL MED.* 795, 798 (2007).

405. DesRoches et al., *supra* note 7, at 191-92.

406. *See Physician Health & Wellness*, AMA Council on Ethical and Jud. Aff. Op. 9.4.2 (2016).

licensing board when . . . conduct . . . poses an immediate threat to . . . patients..⁴⁰⁷

Opinion 9.3.2 Physician Responsibilities to Impaired Colleagues adds that:

[I]ndividually physicians have an ethical obligation to . . . [i]ntervene in a timely manner and ensure that their colleagues receive appropriate care and assistance from a physician health program . . . ⁴⁰⁸

These Opinions raise two problems. First, they appear to set the threshold at which a physician is ethically bound to report to where there is little ambiguity about whether the colleague's conduct is of concern. Second, once that obligation does arise, the reporter faces a rather staggering set of actions for which she is responsible, ranging from notifying a variety of authorities to following up and ensuring that the colleague was appropriately managed. A professional concerned about a colleague may feel intimidated by the process and not confident of back-up if she did report. Unlike other AMA Opinions discussing collective duties,⁴⁰⁹ the Opinions related to compromised colleagues neither charge a medical staff or hospital with making it easier to report nor to assure that if a report is filed, a designated, trained team will step in to manage subsequent steps.⁴¹⁰ Thus, the AMA Ethical Opinions impose too heavy a burden on potential reporters but also do not go far enough to support reporting.

407.*Id.* (emphasis added).

408.*Physician Health & Wellness*, AMA Council on Ethical and Jud. Aff. Op. 9.3.2 (2016) (emphasis added).

409.*See, e.g., Physician Health & Wellness*, AMA Council on Ethical and Jud. Aff. Op. 9.4.3 (2016) (discussing the role of medical societies in assuming responsibility for reporting and addressing incompetent or unethical physician behavior); *Physician Health & Wellness*, AMA Council on Ethical and Jud. Aff. Op. 9.4.2 (2016) (discussing the role of medical staff bodies in assuming responsibility for administering addressing disruptive physician behavior).

410.Webb et al., *supra* note 397, at 150, 152 (2016).

The standards suggested by the AMA Opinions might prove inadequate to prevent patient harm. If colleagues and co-workers do not report concerns and observations about a physician, then there is also the potential for liability if that physician subsequently harms a patient.⁴¹¹ Even in the absence of statutes or organizational policies that expressly define a healthcare professional's reporting duties, courts may use a profession's ethical duties to extend the common law and find liability. The best-known example of this is *Tarasoff v. Regents of the University of California*.⁴¹² The Court found that a psychotherapist whose patient named his intended victim was negligent because he did not directly warn the victim.⁴¹³ The duty to warn outweighed the duty to maintain confidentiality of the patient's sessions.⁴¹⁴ After the decision, the California legislature codified the psychotherapist duty, now called the "duty to protect."⁴¹⁵ Courts could

411. Feinberg, *supra* note 151, at 615.

412. *Tarasoff v. Regents of the University of Cal.*, 551 P.2d 334, 353, (Cal. 1976). The "duty to warn" doctrine dates back to the early 20th century when a physician was held liable for failing to warn the plaintiff's now-deceased husband, who had cared for a neighbor infected with smallpox, that it was a contagious disease. See *Jones v. Stanko*, Admx, 118 Ohio St. 147, 152-53 (Ohio 1928) (discussing that medical professional must know "whether he is dealing with a disease which is dangerously contagious" and must "give due notice" of that fact).

413. 551 P.2d at 340.

414. *Id.* at 347 ("We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.").

415. Cal. Civ. Code § 43.92 (2013) ("(a) There shall be no monetary liability on the part of . . . a psychotherapist . . . in failing to protect from a patient's threatened violent behavior . . . except if the patient . . . communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim . . . (b) . . . the psychotherapist . . . discharges his or her duty to protect by making reasonable efforts to communicate the

potentially extend the duty to other professional colleagues who are aware of a physician evidencing impairment, and fail to act to protect his patients.

Relying on professionals to discharge their ethical duties to report is too tenuous a modality for assuring patient safety. Without a clearly defined process or accessible system for reporting, obstacles may continue to outweigh incentives. Risk of retaliation by the subject of the report, including the possibility of a defamation suit, may be real.⁴¹⁶ A prospective non-physician reporter might fear losing her job if reporting results in the physician's departure. Potential reporters may be influenced by loyalty or friendship,⁴¹⁷ and choose instead to cover-up for their mentor, colleague, or employer's lapses.⁴¹⁸ They may also believe that the leader will back off with the first utterance of denial or threat to sue from the physician,⁴¹⁹ and thus reinforce the futility of reporting.⁴²⁰

Thus, more is needed than relying on observers to report as an ethical duty. A reliable support structure is necessary to assure reporters' psychological safety and freedom from retaliation. Similarly, leaders need to understand how to engage and address outlier physician performance and behavior in a fair and consistent process.

threat to the victim or victims and to a law enforcement agency. (c) the amendments made by the act . . . change the name of the duty referenced in this section from a duty to warn and protect to a duty to protect.").

416. Feinberg, *supra* note 151, at 615.

417. See Richard Rovit, *To Everything There is a Season and Time to Every Purpose: Retirement and a Neurosurgeon*, 100 J. NEUROSURGERY 1123, 1128 (2004) ("a present or former student or associate may be unrea-sonably supportive").

418. See, e.g., Michael A. LaCombe, *Problems of Professionalism: Physician Impairment*, 5 AM. J. MED 654, 655-56 (1996); Blasier, *supra* note 110, at 402.

419. Hickson & Moore, *supra* note 395, at 248-49.

420. Rovit, *supra* note 417, at 1128 (listing reasons why leaders may not follow-through on reports of concerning performance as "fear of bad publicity, legal entanglements, and . . . loss of . . . revenue"); Hickson & Moore, *supra* note 395, at 246-49 (discussing team members' barriers to reporting and leaders' barriers to taking action).

2. The Joint Commission Standards

The Joint Commission ("TJC") has compliance requirements or Standards that, if properly carried out, would identify physicians who fail to meet performance and behavioral expectations.⁴²¹ Hospitals are required to develop processes to enforce these Standards. In collaboration with their organized medical staff, hospitals collect information regarding healthcare professionals' licensure, training, experience, clinical abilities, and competence.⁴²²

The first set of Standards requires hospitals to conduct professional practice review, which consists of two processes: ongoing practice performance evaluations ("OPPE") applied to all physicians,⁴²³ and focused practice performance evaluations ("FPPE") for physicians whose performance raises concerns.⁴²⁴ The second set of Standards requires hospitals to implement a process addressing behaviors that undermine a culture of safety.⁴²⁵ The third set of Standards mandates a process separate from corrective or disciplinary procedures to identify and address physicians who appear to have health or other impairments that may affect their ability to practice safely.⁴²⁶ Identifying physicians with apparent health or impairment issues occurs in the course of carrying out the first two Standards.

All three sets of Standards have, at their core, a philosophy of ongoing surveillance and analysis to identify outliers and address deficiencies. The Standards are broken down into Elements of Performance ("EP"), which hospitals must implement

421. See TJC Standards at MS.08.01.01. Focused Professional Practice Evaluation (FPPE); MS.08.01.03. Ongoing Professional Practice Evaluation (OPPE); SEA #40, *supra* note 377; TJC Standards at MS.11.01.01.

422. See TJC Standards at MS.06.01.03; MS.06.01.07.

423. TJC Standards at MS 08.01.03.

424. TJC Standards at MS 08.01.01.

425. SEA #40, *supra* note 377.

426. TJC Standards at MS.11.01.01.

and demonstrate to TJC accreditation surveyors.⁴²⁷ In addition, TJC offers implementation suggestions for how a hospital might proceed to meet the Standards.⁴²⁸

The first set of standards for OPPE and FPPE transform the traditional “intuitive” credentialing and privileging process into one that is objective and evidenced-based.⁴²⁹ OPPE should be “ongoing” and occur no fewer than three times within the 24-month period between re-appointments to the medical staff.⁴³⁰ This frequency supports early identification of patterns or changes in patterns, as well as intervention.⁴³¹

The OPPE process includes review of two types of metrics: those universal to all medical staff, and those that are specialty-specific.⁴³² Examples of universal metrics⁴³³ are the number of medical record completion delinquencies, prescribing practices, appropriate use of diagnostic testing, and complaints. Everyone with the same privileges

427. See The Joint Commission, *Standards BoosterPack™ for Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE)* 17 (2011) [hereinafter, *BoosterPack*] (“Section A2: Assessing Compliance During the On-Site Survey.”).

428. See e.g., *id.* at 12.

429. *Id.* at 27. TJC Standards at MS.06.01.05 (“The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.”); TJC Standards at MS.08.01.03.03 (“Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges.”).

430. See *BoosterPack*, *supra* note 427, at 12.

431. *Id.* at 8.

432. TJC Standards at MS.08.01.03.02 (“the type of data to be collected is determined by individual departments and approved by the organized medical staff”); see also, Joseph R. Steele et al., *The Joint Commission Practice Performance Evaluation: A Primer for Radiologists*, 7 J. AM. C. RADIOLOGY 425, 426 (2010); Jared M. O’Leary et al., *Curriculum in Interventional Cardiology: Setting Up Professional Standards*, in *TEXTBOOK OF CATHETER-BASED CARDIOVASCULAR INTERVENTIONS* (P. Lanzer, ed. 2018) (in press).

433. *BoosterPack*, *supra* note 427, at 14.

undergoes review of the same specialty-specific metrics.⁴³⁴ OPPE metrics for surgeons, for example, might include wound infection rates, unplanned returns to the operating room,⁴³⁵ observed to expected ("O/E") mortality ratios,⁴³⁶ surgical complication rates,⁴³⁷ and numbers of delinquent operative reports.⁴³⁸ Anesthesiologists' metrics might include re-intubation and spinal headache rates,⁴³⁹ and for hospitalists, length of stay and readmission rates.⁴⁴⁰

The organized medical staff is responsible for developing pre-set FPPE trigger criteria⁴⁴¹ so that "issues affecting the provision of safe, high-quality patient care"⁴⁴² are identified. TJC regulations do not suggest that age would be a permissible FPPE trigger. Data that the healthcare organization already collects for other purposes,

434. See *Steele*, *supra* note 432, at 426.

435. *BoosterPack*, *supra* note 427, at 12. See also, John D. Birkmeyer et al., *Is Unplanned Return to the Operating Room a Useful Quality Indicator in General Surgery?*, 136 ARCHIVES SURGERY 405, 409 (2001).

436. See, *Applying the AHRQ Quality Indicators to Hospital Data*, AHRQ QUALITY INDICATORS TOOLKIT, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/bl-applyingqis.pdf> (last visited Apr. 9, 2018) ("If a hospital's Observed rate for an indicator is higher than its Expected rate (i.e., an O/E ratio greater than 1), then the hospital performed worse than the reference population with an equivalent patient case mix. If the observed rate is lower than the expected rate (i.e., an O/E ratio less than 1), then the hospital performed better than the reference population for that indicator with an equivalent case mix.").

437. Surgical complications are defined as any deviation from the normal postoperative course. See Daniel Dindo et al., *Classification of Surgical Complications A New Proposal with Evaluation in a Cohort of 6336 Patients and Results of a Survey*, 240 ANNALS SURGERY 205, 206 (2004).

438. *BoosterPack*, *supra* note 427, at 12. (medical record delinquency).

439. *Id.* at 14.

440. *Id.*

441. TJC Standards at MS.08.01.01.

442. *BoosterPack*, *supra* note 427, at 4.

like length of stay, infection rates, repeat admissions, numbers of adverse events,⁴⁴³ and patient⁴⁴⁴ and co-worker complaints,⁴⁴⁵ are helpful sources of information, especially when multiple sources or domains appear to show unusual activity. Comparative data—individuals against their peer group—are also a means to surface patterns or unusual changes in performance or behavior that warrant further assessment. Single incidents, including sentinel events, may also trigger FPPE.⁴⁴⁶

When triggered, the organization has a wide range of evaluative tools at its disposal to conduct the FPPE. Medical professionals need to function in several domains: medical knowledge, patient care, practice-based learning and improvement, understanding how to work within a health system, communication and interpersonal skills, and professionalism.⁴⁴⁷ Thus, the individualized assessment may include medical chart review, direct observation of the physician, discussing cases of concern with others involved in the patients' care, and conducting 360° evaluations.⁴⁴⁸

443. *Id.*

444. *Id.* at 24. See also William O. Cooper et al., *Patient Complaints Identify Surgeons With Increased Risk For Postoperative Complications*, 152 JAMA SURGERY 522 (2017) (stating that patients whose surgeon has a history of high numbers of patient complaints are also more likely to experience operative or postoperative complications).

445. SEA #40, *supra*, note 377.

446. *BoosterPack*, *supra* note 427, at 21. TJC defines a sentinel event as one that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition. *Sentinel Events*, CAMH (January 2013), https://www.jointcommission.org/assets/1/6/CAMH_2012_Uupdate2_24_SE.pdf.

447. *BoosterPack*, *supra* note 427, at 3. See American Board of Medical Specialties, *Based on Core Competencies*, <http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/> (last visited Jan. 21, 2018).

448. For 360° evaluations, multiple individuals within the physician's sphere (e.g., nurses, other staff, physician colleagues, leaders) are asked to fill out measurement tools. The physician receives the results as feedback

The OPPE and FPPE rubric is entirely consistent with the ADA's individualized and non-discriminatory approach. TJC regulations allow the hospital an opportunity to identify physicians for extra scrutiny when they trigger an FPPE criterion.⁴⁴⁹ Leaders should be aware of the potential causes of deficient performance and behavior. While not all physicians with poor performance have underlying medical, psychiatric, neuropsychological, or substance abuse issues, some do. Results of OPPE and FPPE may provide the evidence for an employer to develop a reasonable belief that the employee may have a condition that interferes with his ability to do his job or poses a direct threat for which the employer may require examination. In contrast, physicians whose OPPE is satisfactory do not endure special scrutiny solely on the basis of age.

A second set of TJC Standards relevant to monitoring physicians relates to performance deficiencies marked by behaviors that interfere with team members' ability to care for patients⁴⁵⁰ and thereby "undermine a culture of safety."⁴⁵¹ Co-worker complaints are an especially rich source of data as only 3 percent of physicians are associated with three or more co-worker complaints over a 36-month period.⁴⁵² TJC requires hospitals to conduct

and the physician's leader has information to help determine what resources might be needed to remediate. See e.g., Isser Dubinsky et al., *360-Degree Physician Performance Assessment*, 13 HEALTHCARE Q. 71 (2010).

449. The two circumstances for singling out individuals for extra scrutiny are: (1) when OPPE data trigger an FPPE review, see TJC Standards at MS.08.01.01.02 and MS.08.01.01.05, and (2) for a period after initial granting of privileges for new medical staff members and established physicians who request new privileges, see TJC Standards at MS.08.01.01.

450. See Alan H. Rosenstein & Michelle O'Daniel, *A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety*, 34 THE JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 464, 464-65 (2008); Lucian L. Leape et al., *A Culture of Respect, Part 2: Creating a Culture of Respect*. 87 ACAD. MED. 853, 855 (2012).

451. SEA #40, *supra* note 377.

452. Webb, *supra* note 397, at 154, 158 (Figure 4).

stepwise, tiered interventions to hold physicians accountable for these behaviors.⁴⁵³ In one model,⁴⁵⁴ at the first tier a physician peer shares an anonymized co-worker report with the physician who is the subject of the report. If reports continue, intervention escalates in a stepwise fashion up through the administrative tiers. Should co-worker reports persist, leaders may use evaluative resources under the next set of Standards.

The third set of TJC Standards requires medical staff to address health issues or other impairments within a process separate from a corrective or disciplinary procedure.⁴⁵⁵ These Standards have several elements. They charge the medical staff with designing and implementing⁴⁵⁶ processes for educating staff how to recognize⁴⁵⁷ and report observations of behavior or performance consistent with cognitive or other impairments;⁴⁵⁸ maintain informant confidentiality;⁴⁵⁹ and confidentially⁴⁶⁰ manage⁴⁶¹ referrals for necessary assessments⁴⁶² and decision-making.⁴⁶³ The core group managing the process is responsible for referring physicians for physical, mental, and neuropsychological evaluations where appropriate. TJC makes clear in these Standards that they intend case-by-case identification and

453. SEA #40, *supra* note 377.

454. Webb et. al., *supra* note 397, at 152-153; Hickson & Moore, *supra* note 395, at 260-69.

455. TJC Standards at MS 11.01.01.

456. *Id.* at MS.11.01.01.

457. *Id.* at MS.11.01.01.01.

458. *Id.* at MS.11.01.01.03. and 11.01.01.08.

459. *Id.* at MS.11.01.01.03.

460. *Id.* at MS.11.01.01.05.

461. *Id.* at MS.11.01.01.10.

462. *Id.* at MS.11.01.01.04.

463. *Id.* at MS.09.01.01 ("The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts upon reported concerns regarding a privileged practitioner's clinical practice and/or competence.").

management.⁴⁶⁴ These Standards also do not contain language about age-based screening.

TJC's emphasis on the importance of educating staff to recognize dysfunctional behavior is significant. Learning about signs that may indicate illness, substance abuse, or cognitive impairment may lessen denial and rationalization, and increase comfort with reporting. TJC's requirement to establish a process outside of the corrective and disciplinary process is also wise. In making decisions based on data, the management group could determine whether reasonable accommodations would allow the physician identified with a disability to perform his job's "essential functions."⁴⁶⁵

In sum, the TJC Standards related to undertaking OPPE and FPPE and intervening with physicians with unsatisfactory performance or behavior is a valuable tool for creating a non-discriminatory methodology for monitoring all physicians regardless of age. They provide a framework allowing hospitals to achieve their goals of delivering safe, quality care to patients, and treating physicians equitably with attention to their needs. By creating a framework to facilitate reporting, assessment, escalation, and disposition, the Standards provide process regularity and consistency. Importantly, they also establish co-worker reporting and leadership action as normative professional and organizational behaviors. Once the organization identifies dyscompetency or impairment, and evaluates for medical, psychiatric, cognitive or substance abuse conditions, leaders can determine if the physician can fully remediate, return to work with reasonable accommodations, go on long-term disability, or retire.

464.*Id.* at MS 11.01.01 ("The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes.").

465.29 C.F.R. § 1630.2(n) (2016).

*B. Implementing Methods for Detecting and Addressing
Impaired Physicians*

By incorporating Standards that focus on physician performance and behavior into its accreditation process, TJC makes clear to hospitals that these issues matter. Physicians—both individually and collectively as a medical staff—and the hospitals in which they practice, all share responsibility for the quality of patient care. Therefore, they jointly must act to identify and address professionals who are dyscompetent, behave unprofessionally or are cognitively impaired.

To identify and act requires reliable data collection and analysis. Therefore, the joint venture needs systems to ensure that all episodes of unnecessary variation in behavior and performance are recognized, reported, and captured as data points. At the time of its capture, one cannot tell if an event is an isolated one-time occurrence or representative of a deeper pattern or significant problem. Over time, the fuller picture will emerge and reveal who merits a closer look. Database audits help identify unusual complaint patterns, such as where a physician who previously never or rarely received complaints experiences a sudden upsurge in the number of patients expressing concerns.⁴⁶⁶ Sometimes, the content of a single complaint report is sufficient to trigger FPPE. A complaint that “[h]e’s been my doctor for many years, but this time it seemed like he didn’t know who I was” would raise suspicion for cognitive impairment, and the physician would receive prompt attention. If the physician is older, this is a circumstance where the increased variability in cognitive function seen with age serves to heighten suspicion of cognitive issues. In this case, individualized assessment for cognitive impairment is not only non-discriminatory under the ADEA and ADA, but is warranted.

To reliably detect physicians that need focused attention, healthcare organizations must develop the necessary infrastructure to support such programs, including the ability to respond to

466. Fathy et al., *supra* note 56, at E6.

reports of single events and patterns in a consistent manner. Such infrastructure requires:⁴⁶⁷

- Leadership commitment
- Supportive institutional policies, including a non-retaliation policy for good faith reporting
- Sufficient resources to implement and sustain the programs
- Training for co-workers to recognize potential dysfunction
- Accessible and user-friendly reporting systems
- Timely review of all reports, including identifying reports that require urgent handling
- Processes to reliably deliver single reports to the involved physician
- Systems for coding, aggregating, and analyzing reports to identify patterns and outliers
- A model for delivering stepwise, tiered interventions
- Training colleagues to deliver the data
- Prompt leadership involvement when aggregated reports reach a predetermined agreed-upon threshold, or single reports meet criteria for undertaking specific actions, as defined by institutional policy or federal or state law.⁴⁶⁸

467. See James W. Pichert et al., *An Intervention Model that Promotes Accountability: Peer Messengers and Patient/Family Complaints*, 39 THE JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 435, 438 (2013). See also, Hickson & Moore, *supra* note 395, at 253-260; Webb et al., *supra* note 397, at 150-152.

468. See TJC Standards at MS.09.01.01.02. Reports of certain types of events are mandated to be referred to specific offices with expertise. For example, allegations of discrimination are referred to an organization's EEOC office, and allegations of violence or threats of

- Escalation to the next tier when a physician does not respond to intervention or refuses to engage in the process
- A process for careful decision-making based on evidence as to appropriate next steps and disposition, and
- Treating identified physicians with dignity and respect.

Complete discussion of how to implement surveillance programs for performance and behavior, intervene with physicians, and determine further needed assessments and resources falls outside the scope of this Article.⁴⁶⁹ However, the elements of committed leadership and surveillance merit emphasis here because of their critical importance to the infrastructure for detecting and addressing physician impairment and dyscompetency.

Committed and effective leadership is paramount and central to the success of any program for identifying and intervening with potentially compromised physicians. Recent calls for age-based testing are likely, at least in part, a response to circumstances where colleagues or co-workers remained silent when they observed a professional having problems, or where leaders failed to follow through or take appropriate action where there was a need. While it is concerning to think that compromised physicians are practicing medicine, it may be more helpful to assure that leaders have the requisite skills to act fairly, consistently, and reliably. Leaders who “blink” in obvious cases are not likely to fare better when faced with a range

violence are referred to law enforcement. In the case of a physician who exhibits egregious behavior, i.e. is engaged in a serious breach of normative behavior or there is evidence to suspect s/he may be impaired for any reason.

469. See e.g., Gerald B. Hickson et al., *Balancing Systems and Individual Accountability in a Safety Culture*, in FROM FRONT OFFICE TO FRONT LINE: ESSENTIAL ISSUES FOR HEALTH CARE, 1-35 (Steven Berman ed., 2nd ed. 2012) (discussing the use of a “project bundle” as an approach for optimizing successful deployment and sustainability of important projects, especially within health systems).

of hard-to-interpret results after testing all of their older physicians.

The infrastructure must also have methodology for ongoing surveillance. Without it, the result may be policies like those taking aim at late-career physicians. Without reliable processes to identify outlier performance and behaviors, leaders may view age-based cognitive testing as a way to demonstrate they are "doing something" in response to a perceived serious problem. They may further believe that only an age-based screening program will give them the "objective" testing data they need to act. Yet, because such "fishing expeditions" are discriminatory and fail to evaluate all members of the medical staff, hospitals need an alternative approach. By following TJC Standards related to performance and behavior; implementing the elements of the infrastructure, including monitoring and analyzing data for all physicians; following the EEOC ADA guidance; and offering a dignified process for potentially compromised physicians, an organization will achieve a nondiscriminatory process that also protects patient safety.

One remaining issue is to determine how to monitor physicians unaffiliated with a larger practice, hospital, or health system. In these circumstances, state medical boards could step in. The role of state administrative oversight is especially important for physicians in solo practice. States already receive complaints about physicians.⁴⁷⁰ Whereas medical boards currently may only assess each complaint for "face validity,"⁴⁷¹ adding methodology to code all received complaints, aggregate, and then analyze the data for patterns would help identify outlier physicians. Another option for monitoring unaffiliated physicians would be to develop a process similar to what CPSO does in Ontario, in which licensing board representatives

470. See, e.g. James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889, 1889 (1998) (finding that 63% of complaints reported to the California Medical Board are made by the public, 19% are from government agencies, and 14% are from insurers); Clay & Conatser, *supra* note 152, at 82.

471. Morrison & Wickersham, *supra* note 470, at 1889.

visit practices and perform a practice assessment. If the physician demonstrates dyscompetency, the state would refer for further evaluation and potential remediation.

*C. The Challenge of Providing Reasonable
Accommodations for Cognitive Impairment*

In compliance with the ADA, a healthcare organization must determine whether an employee with cognitive impairment can perform her job with or without reasonable accommodations.⁴⁷² Such accommodations may include: switching the practice over to office-based from procedure-based, scheduling longer appointment times with each patient, using memory aids, and seeking input from professional colleagues.⁴⁷³ From the physician's perspective, these accommodations may be sufficient to support her ability to practice safely. In a real sense, however, the organization must dedicate itself to monitoring surveillance data and performing regular job-related medical examinations to evaluate whether the accommodations are sufficient. The status of a physician whose current cognitive function is adequate to perform the job's essential functions may change over time, with the rate of decline more rapid than expected.

Hospitals should also consider the patient's perspective. While some patients might accept treatment by a physician with cognitive impairment, some will not. Informed consent cannot remedy any discrepancy between the care the patient should receive from that physician and what the physician actually is able to provide.⁴⁷⁴ Thus, it may be that a physician who has been diagnosed with cognitive impairment should not continue in practice even if accommodations might somewhat ameliorate contributing stressors or the impact of the disability on patient care.⁴⁷⁵ Moreover, because the

472.42 U.S.C. §12111(9) (2017); C.F.R. § 1630.2(o) (1) (i-iii) (2016).

473.Moutier, *supra* note 110, at 19.

474. See 42 C.F.R. 482.13 (c) (2) The patient has the right to receive care in a safe setting.

475. There are currently no tools that can predict the impact of cognitive impairment on a practice. See text and

most salient major life activity⁴⁷⁶ impacted in physicians with cognitive impairment is "thinking,"⁴⁷⁷ perhaps practicing medicine is one job for which no reasonable accommodations exist that sufficiently compensate. The ideal middle ground, honoring the physician's desire to continue practicing and the patient's need for safety, may require an accommodation of close supervision by another physician. If such an accommodation posed "undue hardship" to the hospital⁴⁷⁸ and, therefore, was not reasonable under the ADA, then the physician would need to separate, either by retiring or going on disability.

accompanying notes to Thompson, *supra* note 140, and text and accompanying notes to Adler & Constantinou, *supra* note 141.

476. See Doyal v. Oklahoma Heart, Inc., 213 F.3d 492, 495-96 (10th Cir.2000), *citing* Pack v. Kmart Corp. 166 F.3d1300,1305 (10th Cir.1999) ("That term has been construed to mean a 'basic activity that the average person in the general population can perform with little or no difficulty.'").

477. 42 U.S.C. § 12102(a)(2)(A) (2008) (adding "thinking" as part of the definition of "major life activities"); See Sanchez v. ACAA, 246 F.Supp.2d 61,71-2 (2003) ("[Plaintiff] has presented sufficient facts regarding his mental condition, and particularly regarding his capacity to think as compared to the general population, to create a triable issue on this score."); Taylor v. Phoenixville School Dist., 184 F.3d 296, 307 (3rd Cir.1999) ("We accept that thinking is a major life activity."); Nawrot v. CPC Int'l, 277 F.3d 896, 903 (7th Cir.2002) ("[. . .]his impairment substantially limits his ability to think and care for himself[. . .]"); Doyal v. Oklahoma Heart, Inc., 213 F.3d 492 (10th Cir.2000).

478. 29 C.F.R. § 1630.2(p) (2016). See Bates v. United Parcel Service, Inc., 511 F.3d 996-997 (9th Cir. 2007) ("To show that 'performance cannot be accomplished by reasonable accommodation,' the employer must demonstrate either that no reasonable accommodation currently available would cure the performance deficiency or that such reasonable accommodation poses an 'undue hardship' on the employer. See 42 U.S.C. §§ 12113(a), 12111(10) (2006).").

V. Conclusions

Over-concern about older physicians' competency and cognition, and the failure of the medical community to report or take action when warranted, are behind the drive to implement age-based cognitive screening programs for late-career physicians. Current proposals to screen all older physicians waste resources and represent a poor pragmatic strategy that will lead to unwarranted scrutiny of large numbers of competent physicians, under-identification of non-targeted individuals who actually pose risk to patients, and discrimination under the ADEA and the ADA. Healthcare organizations should instead develop comprehensive and effective plans to identify physicians of all ages whose impairment or dyscompetency can affect patient safety.

The focus should be on supporting systems that collect and use performance data to identify outlier physician behavior or performance, concentrating efforts on elucidating the reasons for the outlier status, and assuring that leaders reliably address potentially impaired physicians. The approach recommended in this Article involves three basic elements: first, the healthcare organization should use reliable and non-discriminatory methods to detect physicians with outlier performance and behavior by strengthening their surveillance and assessment systems. These systems would include a vigorous OPPE/FPPE program to receive and analyze physician data from multiple domains, including metrics for quality indicators, compliance requirements, and patient and staff complaints. Second, the systems should include accessible reporting tools for the entire workforce, and prompt review and management of all reports. Third, leaders need to establish a protected venue, such as a wellness committee, from which they coordinate assessments to help determine which physicians: require remediation; can practice safely with reasonable accommodations and monitoring; or need to separate from the organization. Throughout the process, healthcare organizations must treat physicians with dignity and respect.

The framework is ready. The incentives and regulatory authority are in place. Healthcare leaders now must monitor and act to ensure that medical professionals practice safely, and not allow discriminatory impulses to distract them.