The Aging Physician: Balancing Safety, Respect, and Compliance

Jonathan H. Burroughs, MD, MBA, FACHE, FACPE
The Burroughs Healthcare Consulting Network Inc.
Glen, NH

James B. Hogan, Esquire
Jennifer H. Richter, Esquire
Hall Render Killian and Lyman PC
Indianapolis, IN

The aging physician is a difficult issue for the medical staff to address on many levels. The medical staff's core values of autonomy and advocacy create both respect for an individual to make professional judgments and an unwillingness to make determinations that may threaten the physician's identity as an independent professional. Although these attitudes are slowly eroding with the growing number of employed physicians, the medical staff has been reluctant to cede authority regarding the assessment of competence and conduct to human resources (HR) even though the employer has an obvious legal interest. The potential conflict between HR and the medical executive committee regarding the evaluation and management of performance issues should always be negotiated in advance and memorialized in both hospital and medical staff policies and procedures. The medical staff bylaws should clearly articulate the relationship between the approach of the organized medical staff and any relevant employment contracts. For instance, many bylaws indicate that when "there is conflict between the bylaws and an employment contract, the contract shall prevail." In addition, relevant HR policies/procedures need to address the relationship between the hospital and medical staff's approach when there is overlap such as in the area of professional conduct, potential impairment, and the like. Many healthcare organizations encourage the medical staff to implement peer review through a focused professional performance evaluation when concerns are raised regarding the exercise of current clinical privileges. However, once that assessment and analysis is complete, management is permitted to utilize the terms of the employment agreement to exercise any progressive discipline necessary.

Many medical staffs are finally addressing the aging process as a distinct form of potential impairment as it requires sensitivity and respect for both the practitioner and relevant laws. There is excellent data that when a physician (or any professional) reaches their 60s and 70s, there is a significant and progressive decline in cognitive and physical skills. For instance, in 1994 Harvard psychologist and researcher Dr. Douglas Powell published his landmark and controversial work, "Profiles in Cognitive Aging," in which he compared more than 1,000 physicians and 600 non-physicians from ages 25-92. He found that overall, physicians scored higher in cognitive functioning from ages 25-55 but that thereafter, there was a consistent and more precipitous decline with increasing age in the areas of cognitive function (as measured by the Micro-Cog assessment tool), inductive reasoning, verbal memory, and overall reasoning and that the overall scores of the two comparative groups began to equalize with increasing age.[1]

Interestingly, most physicians successfully modulate their practice appropriately with age. Most medical staffs have a significant number of physicians entering their 60s and a much lower number entering their 70s. This corresponds to a time when most physicians find the rigors of night call, managing critically ill or injured patients, long work weeks, and sleep deprivation taxing. In response, they modify their practice to allow shorter work weeks in the care of more clinically stable patients during daytime hours. This enables physicians to continue to practice in a more sustainable way that is also safer for patients.

There are, however, a small number of physicians who either cannot perceive their declining performance or who are unwilling to make necessary changes to their practices. In such cases, the healthcare organization must create a credible approach that balances the dignity and rights of the physician with the need to protect patients from potential harm. Unfortunately, many organizations wait for an adverse event to take formal action. That process may trigger procedural rights under the Healthcare Quality Improvement Act[2] (HCQIA) if the medical staff: (1) initiates a formal peer review investigation; or (2) is forced to involuntarily restrict the physician's privileges.

While the fair hearing process is an appropriate response to many quality concerns, it is not the ideal first option when dealing with aging practitioners. For example, one approach is to pick an age (typically 70) when the medical staff shortens the appointment period from two years to one year and requires a "fitness for work" evaluation performed by a qualified vocational professional that is hired by the organization and reports directly to medical staff leadership and management. Such an evaluation is not a physical examination by a primary care practitioner, but rather a vocational evaluation that compares a practitioner's cognitive and physical evaluation to the specific functions required of the clinical privileges requested. Individuals qualified to perform such evaluations may be found through specific organizations (e.g., Physical Assessment and Clinical Education at the University of California, San Diego; Colorado Physician Education Program in Denver, CO) or through each state's board of registration in medicine which has a list of qualified individuals under contract or agreement with the licensing board to provide such evaluations in the event of a formal investigation. Based upon this report, the medical staff can either recommend the practitioner continue exercising their current clinical privileges or can work with the practitioner to voluntarily modify the scope of privileges to be consistent with his/her practice capabilities and safe patient care.

Another strategy medical staffs employ is to relieve physicians from night call at a certain age (often 60-65) and recommend the physician transition from inpatient to outpatient privileges where the patients are more stable and can be cared for during daytime hours. These two approaches are proactive, addressing issues ***before*** they become problems. As long as the physician can see the wisdom of working with the staff voluntarily and physician leaders can frame the process in a positive and supportive light, these types of options can significantly extend the physician's professional career, which is supportive of the medical staff's values of autonomy and advocacy.

In the absence of a more proactive approach, or where concerns have arisen despite them, the medical staff must consider the available options. Here the first step is to identify the nature of the physician's relationship and the applicable policies, regulations, and statutes. A hospital's relationship with non-employed physicians is governed by the medical staff bylaws, rules, regulations, and policies (collectively, Bylaws). Hospital-employed physicians are not only subject to the Bylaws, but also the parties' written contract and related hospital policies. Physicians employed by a group practice are subject to their written employment agreements, in addition to other potentially relevant documents such as the articles of organization, operating agreement, partnership agreement, etc.

The Bylaws identify specific procedural steps to address a physician's competence or professional conduct. The Bylaws may require an issue with an aging physician to be forwarded to the medical staff physician assistance committee (PAC). The PAC approaches the concern from the perspective of potential impairment, i.e., a physical or psychological condition that is impacting physician performance. Once initiated, the PAC may refer the practitioner for an independent evaluation to assess whether there is a medical-based cause of the performance issue. Based on the recommendations received, the practitioner may be referred for treatment, additional professional education, and/or be subject to proctoring or similar oversight. In cases where significant issues are identified, the physician could be asked to voluntarily decrease his/her scope of privileges; otherwise, the practitioner could be subject to restriction or revocation of their privileges. This process is conducted under the peer review privilege. It may be similar to the fitness-for-work evaluation discussed above, or go beyond it, depending on the presenting circumstances.

If the physician refuses to cooperate with the evaluation process, or if the process results in a recommendation of limitation of privileges, the physician is entitled to a fair hearing under the Bylaws if appropriate policies do not mandate a voluntary withdrawal of membership and privileges in the case of non-compliance. If the medical staff prevails in that process, a report is filed with the National Practitioner Data Bank (Data Bank). The medical staff and the participants in the fair hearing process are entitled to immunity from damages under HCQIA[3] and applicable state law, with the exception of actions alleging civil rights or antitrust violations. Therefore, aging physicians whose privileges are subject to adverse action frequently pursue claims under several different civil rights statutes, including the Americans with Disabilities Act (ADA)[4] or the Age Discrimination in Employment Act (ADEA).[5]

In examining these claims, the initial threshold question is typically whether or not the physician is an "employee" for purposes of the ADA or the ADEA. The existence of a written agreement between the parties, or even their understanding of their relationship, will not be determinative. Instead, courts utilize a common-law agency test when analyzing the nature of the relationship, and while the existence/absence of a written agreement is a consideration, the facts and circumstances of each situation are assessed considering the following factors:

- Hiring party's right to control the manner and means by which the product is accomplished;
- Skill required;
- Source of the instrumentalities and tools;
- Location of the work;
- Duration of the relationship;
- Whether the hiring party has the right to assign additional projects to the hired party;
- Extent of the hired party's discretion over when and how to work;
- Method of payment;
- Hired party's role in hiring and paying assistants;

- Whether the work is part of the regular business of the hiring party;
- Whether the hiring party is in business;
- Provision of employee benefits; and
- Tax treatment of the hired party.[6]

In recent years, the volume of employment law claims filed by physicians against hospitals has increased. This increase, in part, is a function of the trend of hospitals to directly employ physicians. However, in many cases the claims have been brought by physicians whom the hospitals never intended to be employees. While the parties may not have intended an employment relationship, a court may still determine that such a relationship exists. If so, the physician is entitled to the protections of Title I of the ADA as well as the ADEA. Not only does this open unanticipated employment law exposure for the hospitals addressing issues with aging physicians, such claims would also not be subject to HCQIA immunity.

To the extent a hospital and/or medical staff takes action against an aging physician based on concerns over the physician's ability to physically or mentally perform the job, the physician could claim their privileges were restricted due to a disability covered by the ADA, equating to discrimination under the ADA. The ADA defines disability as: (1) a physical or mental impairment that substantially limits one or more major life activities; (2) a record of having such an impairment; or (3) being regarded as having such an impairment.[7] In the event a physician claims to have a disability, there are additional obligations placed on the *employer* under the ADA to engage in what is referred to as the "interactive process" and determine whether there is a reasonable accommodation that would enable the physician to perform the essential functions of the job.

In *Mattice v. Memorial Hospital of South Bend*,[8] Dr. Mattice had a history of depression and panic attacks, and had taken leaves of absence to address these conditions. After he returned to practice, a patient died while under his anesthesia care. After a medical staff hearing and appeal, the physician was placed under a monitoring and testing agreement. Mattice alleged the agreement made it impossible for him to practice, and constituted unlawful discrimination against him based on conditions covered by the ADA.

Memorial filed a motion to dismiss early in the litigation, in part, on the basis that the court lacked jurisdiction over Mattice's ADA claim because he was not an employee but rather an independent contractor. The court denied the motion without ever getting to the issue of whether Mattice was an employee. Instead, the court stated that because Mattice claimed to have been an employee of a third-party physician practice, he could seek ADA liability upon the theory that the hospital interfered with his practice employment on the basis of a disability.[9] This demonstrates yet another avenue in which a non-employee member of the medical staff could pursue a discrimination claim.

Practice Groups Staff

Trinita Robinson
Vice President of Practice Groups
(202) 833-6943
trobinson@healthlawyers.org

Magdalena Wencel
Senior Manager of Practice Groups
(202) 833-0769
mwencel@healthlawyers.org

K. J. Forest
Practice Groups Distance Learning Administrator
(202) 833-0782
kforest@healthlawyers.org

Brian Davis
Practice Groups Communications and Publications Administrator
(202) 833-6951
bdavis@healthlawyers.org

Crystal Taylor
Practice Groups Activities Coordinator
(202) 833-0763
ctaylor@healthlawyers.org

Tazeen Dhanani
Practice Groups Web Assistant
(202) 833-6940
tdhanani@healthlawyers.org

Dominique Sawyer
Practice Groups Distance Learning Assistant
(202) 833-0765
dsawyer@healthlawyers.org

Graphic Design Staff

Mary Boutsikaris
Creative Director
(202) 833-0764
mboutsik@healthlawyers.org

Ana Tobin
Graphic Designer/Coordinator
(202) 833-0781
atobin@healthlawyers.org

The ADEA provides statutory protections for employees 40 years of age and older. More specifically, the ADEA prohibits employers from: (1) failing or refusing to hire or discharging any individual or otherwise discriminating against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age; and (2) limiting, segregating, or classifying employees in any way that 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.[10]

The ADEA's prohibitions of singling out individuals based on age raises potential concerns with respect to policies regarding mandatory physical examinations for physicians once they reach a certain age. When the triggering event of a physical examination is solely based on age, and there are no other specified concerns regarding the physician's ability to perform the job, there is potential exposure for an ADEA discrimination claim, assuming the physician can establish he/she is an "employee."

The ADEA provides an exception to the prohibition on such age-based policies in circumstances where an employer can establish that the age-related requirement is a bona fide occupational qualification (BFOQ).[11] To meet the BFOQ standard, an employer must establish that the job qualifications are reasonably necessary to the essence of the business and that the employer is compelled to rely on age as a proxy for the safety-related job qualification.[12]

Advice Going Forward

Recognizing the potential legal implications when addressing aging physicians, medical staffs should proceed under clear, consistently applied policies. The focus should be on the quality of care provided by the physician. If there are concerns regarding an aging physician's ability to safely perform the functions of their role, requesting a medical evaluation is job related and consistent with business necessity, and not problematic under the ADA. Some institutions have adopted a policy that all physicians must undergo an annual physical attesting to their good health once they reach a certain age. Another approach is to shift from a two-year to one-year reappointment period once a physician reaches a predetermined age. Ultimately, the legality of such policies under the ADEA will hinge on: (1) whether the physician qualifies as an "employee"; and (2) whether the policies can meet the requirements of a BFOQ.

Navigating through the potential discrimination allegations with an aging physician can be challenging, but demonstrable quality issues must be appropriately addressed. Pushing too aggressively or in a manner perceived as discriminatory may result in a suit from an older physician. However, failing to address the issue may result in a patient claim for negligent credentialing or a similar cause of action. It is essential these occasionally opposing legal obligations are carefully balanced.

Ideally, hospitals and medical staffs will be proactive, considering the issues involved with aging physicians in advance and adopt policies tailored to address these issues before concerns arise. In some cases, the circumstances or practitioner response will leave no option but to pursue corrective action, fair hearings, and potentially a Data Bank report. However, this avenue should be considered a last resort. Where possible and with the physician's cooperation, the aging practitioner's transition into the final phases of their career should be managed respectfully and with appropriate consideration of their contributions to the hospital and the patients they served.

1 Powell, Douglas H., *Profiles in Cognitive Aging*, Harvard University Press, December, 1994.
2 42 U.S.C. § 11101 *et seq.*
3 42 U.S.C. 11101 *et seq.*
4 42 U.S.C. § 12111-12117.
5 29 U.S.C. § 621.
6 *Community for Creative Non-Violence v. Reid*, 490 U.S. 730, (1989).
7 42 U.S.C. § 12111-117.
8 203 F.R.D. 381 (N.D. Ind. 2001).
9 *Mattice v. Memorial Hospital of South Bend*, 1999 U.S. Dist. LEXIS 20933, *25-26 (N.D. Ind. March 1, 1999).
10 29 U.S.C. § 623(a).
11 29 U.S.C. § 623(f)(1).
12 *See Western Air Lines v. Criswell*, 472 U.S. 400, 413-14 (1985).