ASSESSING LATE CAREER PRACTITIONERS:
Policies and Procedures for Age-based Screening

A Guideline from
California Public Protection and Physician Health, Inc.

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Introduction

The implications of greater human longevity generally and a rapidly increasing work-life expectancy are complex and the subject of intense study, particularly as they relate to the delivery of health care. Ensuring that the U. S. health care system will have the workforce capacity needed to deliver care to the increasing numbers of patients that have been projected has been identified as a priority.

On the one hand, studies show that greater levels of experience in medicine, as in other industries, result in higher quality care. We ascribe benefit to the greater experience accumulated with more years of practice being brought to bear on patient-care decisions by physicians and other health care workers.

On the other hand, studies also demonstrate that the effects of aging directly impact the specific physiological and cognitive functions relied upon by physicians in carrying out their job-related responsibilities. In fact, studies have found a direct correlation between decline in these areas of function and adverse outcomes for patients. The studies cited in the appendix necessitate an examination of how to evaluate and address any decline in levels of function that might impact patient care and a consideration of whether using age as a factor in our evaluation mechanisms is an effective way of protecting patients.

The legal framework surrounding this issue is responsible for additional complicating forces. Both Federal and State law mandate that entities that employ, contract with or grant privileges to physicians to provide services to patients—including hospitals, medical staffs, and physician groups —engage in active oversight of the quality of care rendered by physicians practicing at their facilities. Case law clearly establishes that hospitals and physician groups can be held directly liable for injuries caused to patients by physicians where there was evidence of deficiencies in the physician's skills or judgment that posed a danger to patients.

The law does not, however, allow unfettered discretion to entities charged with the responsibility of quality oversight. The law has created an expansive view of the property right of members of medical staffs to practice their trade free from arbitrary actions by hospitals, medical staffs and others. This includes a physician's right to be free from discrimination based on race, color, gender, sexual orientation, national origin, age and disability. Thus is created the dynamic tension between the need to protect the public and the patient and the need to protect the individual healthcare provider.

Statement of purpose

This document is intended to assist all those in medical staffs, medical groups, and other entities that have responsibility for decisions related to evaluating a practitioner's health and wellbeing as they impact the practitioner's ability to practice medicine safely. (Hereinafter, the document uses "medical staff" to refer to all the entities with this responsibility.) The document describes guidelines and principles and provides information specific and detailed enough to form the basis for decisions to be made by each entity. It does not replace the judgment of the decision makers applied to individual circumstances.

This paper will also review the evolution and impact of age and disability discrimination laws on the options available for evaluating physician competency. As will be seen, age and disability discrimination laws have unique aspects that in many ways grant flexibility to institutions in shaping policies and actions designed to address quality and protect patients. These laws are complex and care must be exercised in creating and implementing policies so as to maintain the values that underlie the extensive network of laws that prohibit discrimination. This paper will examine the intersections of the multiple competing forces in the discussion of the available options for assessing physicians who choose to work late into their careers.

Most importantly, this paper will posit that this issue can be properly addressed only if it is addressed by all stakeholders as a shared responsibility: by practitioners who, ideally, should assess their own level of skill and any changes which might impact their ability to deliver quality care and by institutions responsible for maintaining quality care and protection of the patients. To be effective and successful, policies and procedures must balance the interests of all involved in assuring safety of patient care.

A necessary starting point is an examination of the studies that identify and quantify the impact of age on quality, and the implications of these data for entities charged with ensuring quality.