Late Career Practitioner Policies and the Role of Wellbeing Committees in Credentialing Procedures

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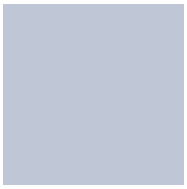

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As a significant portion of healthcare providers approach the age of retirement, there is an increasing demand for qualified and experienced practitioners.[1] This demand is juxtaposed against an awareness that some factors associated with aging may negatively impact physicians' cognitive and physical abilities.[2] Industry and medical staff leadership have therefore expressed increasing interest in the development and implementation of policies regarding the credentialing of "aging" or "late career" practitioners.[3]

Should a medical staff choose to develop such a policy, which we recommend for both appointment and reappointment purposes, a series of decisions regarding the policy's framework and implementation must be made.[4] In 2015, the California Public Protection & Physician Health (CPPPH) published a comprehensive analysis of this issue entitled *Assessing Late-Career Practitioners: Policies and Procedures for Age-based Screening, A Guideline from California Public Protection & Physician Health*. It includes a thoughtful analysis of issues and considerations regarding this type of policy. For the most part, the authors agree with the guidance provided by CPPPH and recommend this publication as a resource to any medical staff contemplating this type of policy. However, there is one area where there is fundamental disagreement, which is the focus of this discussion.

CPPPH has taken the position that "[b]ecause of its charge to advise and assist the members of the medical staff and to maintain confidentiality of the information except when the safety of a patient is threatened, the Wellbeing Committee is the most appropriate committee to be responsible for implementation of the policy up to the delivery of its recommendation to the practitioner and to the Credentials Committee."[5] Placing the Wellbeing Committee (Wellbeing) as the focal point of the assessment is, in our view, misguided.

First, there is no legal distinction between these committees regarding the scope of confidentiality protection that applies to their records.[6] In addition, Wellbeing already plays an important role with respect to the members of the medical staff with identified health problems. It would be problematic to expand that role to include operating as an additional Credentials Committee. Credentialing is not a function of Wellbeing and a senior physician being sent to a committee that deals with established health issues sends the wrong signal. CPPPH's recommendation to make Wellbeing responsible for processing credential applications for members of a certain age also undermines the medical staff's ability to defend

against potential legal challenges.

The potential for discrimination claims when age is used as an initial criterion for increased scrutiny is readily apparent.[7] Federal and state laws which prohibit age discrimination declare that age shall not be used to adversely affect any individual.[8] But the laws are noteworthy for their exceptions.[9] Unlike race, religion, nationality and other immutable characteristics, physical and cognitive decline associated with age have been recognized by Congress, state legislatures and courts as posing risks in the workplace, particularly where public safety is at issue.[10] Any policy which incorporates age-based screenings must carefully consider the law in this area.

Generally speaking, there is legal support for the proposition that a healthcare entity may establish a standard for granting or maintaining medical staff appointment if that standard is rationally related to the delivery of quality health care to patients.[11] For example, under the Age Discrimination Act of 1975, there is an exception if "in the program or activity involved [s]uch action 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; or the differentiation made by such action is based upon reasonable factors other than age."[12] Efforts must therefore be made to minimize the changes to existing credentialing procedure. The policy should augment, not completely alter, the medical staff's existing application process. Further, the changes implemented must be rationally related to improving the quality of care.

The Credentials Committee is the entity typically responsible for the collection, verification and evaluation of information relating to the determination of whether to grant appointment and reappointment to the medical staff.[13] It has the experience and expertise to process reapplications to the medical staff. It is ill advised, upon deciding to implement what may already be a controversial policy, to put the processing of critical information into the hands of a committee which plays no role in the credentialing process.

According to the California Medical Association and CPPPH, Wellbeing acts as an educational resource "for medical and other organization staff in matters related to maintenance of health and prevention of impairment."[14] It "provides an informal, confidential access point for persons who voluntarily seek their counsel and assistance" and is "a source of expertise whereby the medical staff may identify health factors underlying a clinical performance problem for which corrective action is under consideration."[15] Thus, Wellbeing is utilized once the practitioner or medical staff leadership has already identified an issue with clinical performance.[16]

Because "the effect of age on any individual physician's competence can be highly variable," age – by itself – is not rationally related to CPPPH's recommendation to have the application processed by Wellbeing.[17] CPPPH's recommended approach would create a medical staff with two committees processing applicants where the only difference between pending applications is the age of the applicant. Even if Wellbeing were to be given additional support staff and adequately trained in processing the applications, there is still significant risk of inconsistent recommendations between the two committees when faced with similar facts.

There is an argument that Wellbeing is focused on the individual practitioner while the Credentials Committee emphasizes patient care, the medical staff, and governance.[18] Even if this is true, there is no need for any increased focus on the practitioner until a specific issue is identified. It unnecessarily undermines the medical staff's ability to defend against claims of disparate treatment when a practitioner with a long and successful career is subjected to a different committee's review based solely on age.[19] The problem is compounded by the reality that, to some practitioners/potential plaintiffs, there is a stigma attached to being sent to Wellbeing.

Should a medical staff choose to adopt a late career policy, it is recommended that it be implemented in a manner that minimizes disparate treatment based on age and focuses instead on identifying and addressing actual concerns which may arise. It is only at this juncture that involvement of Wellbeing should be contemplated.

[1] According to the Association of American Medical Colleges (AAMC) 2017 State Physician Workforce Data Book, 30.9% of the physician population is 60 years of age or older.

[2] *See* McDade, *Competency and the Aging Physician, Report of the Council on Medical Education* (2015) ("AMA Report"); California Public Protection & Physician Health, *Assessing Late-Career Practitioners: Policies and Procedures for Age-based Screening, A Guideline from California Public Protection & Physician Health* (2015) ("CPPPH Guideline"); *see also* E.P. Dellinger, et al., *The Aging Physician and the Medical Profession, A Review*, (July 19, 2017) JAMA Surgery, October 2017, Volume 152, Number 10, p. 968 (declaring that "[a] robust literature has developed regarding the effect of age on physicians' performance. [...] Thus, while age alone may not be associated with reduced competence, the substantial increase in variation around cognitive skills as physicians age suggests the issue cannot be ignored.").

[3] The vocabulary in the area is varied and evolving. The American Medical Association, for example, uses "Aging Physician" while Stanford Health Care, one of the early adopters of this type of policy, and CPPPH use "Late Career Practitioners." (The authors disclose that they represent Stanford Health Care on a variety of matters, including its Late Career Practitioner policy).

[4] The authors are not taking a position as to the threshold question of the appropriateness of late career policies in any given set of circumstances. Determining whether such a policy is a viable option for a medical staff requires a case by case analysis, including consideration of the location, size, and practice area composition of the respective medical staff, among other issues. The role of various political dynamics should also be taken into consideration. It is recommended that any medical staff interested in exploring this issue seek legal counsel.

[5] CPPPH Guideline, p. 7 at ¶9.

[6] *See* California Evidence Code § 1157 (referencing "organized committees" and "peer review body" without specific reference to distinct committees).

[7] This article is not intended to be a comprehensive review of laws relating to potential age discrimination claims. It is instead focused on a specific aspect of the procedural implementation of these types of policies.

[8] *See*, *e.g.*, 42 U.S.C. § 6101; Cal. Gov't Code § 12940(a); *Alch v. Superior Court*, 122 Cal.App.4th 339, 392, n.53 (2004).

[9] This article expresses the opinion of the authors and is presented for general discussion and consideration. It does not constitute legal advice nor should it be used as a substitute for obtaining legal counsel. A review of the specific language of a proposed policy in connection with applicable law – which varies by jurisdiction – must be undertaken by each medical staff prior to any efforts to draft and adopt this type of policy.

[10] For example, pilots, air traffic controllers, and federal law enforcement and firefighters all have mandated retirement ages. *See*, *e.g.*, 49 U.S.C. § 44729; 29 U.S.C. § 623(j). Indeed, pilots are subjected to increased review as young as age 40. https://www.gpo.gov/fdsys/pkg/FR-2008-07-24/pdf/E8-16911.pdf.

[11] *See Miller v. Eisenhower Medical Center*, 27 Cal.3d 614, 628 (1980); *Oliver v. Board of Trustees*, 181 Cal.App.3d 824, 830 (1986). "A rule or policy decision of general application adopted by the governing authority of a hospital [...] impinging on the right of a physician to practice his or her profession fully will not be set aside by a court unless it is substantively irrational, unlawful or contrary to established published policy or procedurally unfair." *Lewin v. St. Joseph Hospital of Orange*, 82 Cal.App.3d 368, 385 (1978); *see also Hay v. Scripps Memorial Hospital*, 183 Cal.App.3d 753, 761 (1986).

[12] 42 U.S.C. § 6103(b)(1); *see also* 34 C.F.R. §§ 110.12.

[13] K. Rieger, *The Medical Staff Guidebook: Minimizing Risks and Maximizing Collaboration* (American Health Lawyers Association, Fourth Edition) (2016), pp. 69, 83.

[14] CMA Legal Counsel and CPPPH, *Guidelines for Physician Well-Being Committees Policies and Procedures* (CMA On-Call Document #5177) (September 2013).

[15] *Id*.

[16] The authors are not advocating for the Wellbeing Committee's involvement every time an issue is identified. For example, if the identified issue can be addressed through training or physical rehabilitation and strengthening, there would be no need to involve the Wellbeing Committee.

[17] *See* AMA Report, Executive Summary.

[18] The authors do not take a position as to the validity of this assertion.

[19] Any analysis of potential claims or assessment of liability is highly fact dependent. This possible argument is raised here only for the purpose of this hypothetical discussion and without regard to the viability of such a claim.

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