Physicians and Cognitive Decline: A Challenge for State Medical Boards

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ABSTRACT: Older physicians benefit from their many years of experience and the skills they have developed over decades of practice. At the same time, they may be at risk of cognitive decline, which raises concerns about job performance deficits. The question that this article addresses is whether state medical boards have a role to play in identifying clinicians with cognitive decline. It discusses what state medical boards currently do in this regard and analyzes whether they should do more. It also discusses relevant legal constraints and ethical obligations. The article ultimately concludes that state medical boards would be wise to adopt late career screening programs that are carefully designed to balance the interest of clinicians and patient safety. Such programs could be implemented only after experts determine which preliminary tests and more comprehensive follow-up tests can best identify job-related cognitive impairment and at what age the testing program should commence. Any testing program would have to include due process protections, efforts to provide reasonable accommodations to facilitate job performance, and a public relations campaign to build support among clinicians and professional organizations. Although the article focuses on state medical boards, its analysis and recommendation are relevant to all state licensing boards that oversee health care providers.

Introduction

Dr. Tia Powell, a leading psychiatrist and bioethicist, warns of a "looming public health crisis of aging physicians."[1] What she is concerned about is cognitive decline.

More than 15% of the approximately 1,062,200 practicing physicians in the United States[2] are over 65 years old.[3] According to the Alzheimer's Association, most individuals with Alzheimer's disease are seniors. The risk of Alzheimer's doubles every five years after age 65, and almost one-third of people who are over 85 have the disease.[4]

Physicians are not immune to this affliction. According to one estimate, as many as 28% of US physicians with active licenses who are aged 70 and older have mild cognitive impairment or dementia.[5]

The problem is not restricted to physicians alone. In 2016-2019 Yale New Haven Hospital tested 141 clinicians who were 70 or older and sought reappointment to its medical staff. The majority (125) were physicians, but others were advanced practice registered nurses, dentists, psychologists, podiatrists, a physician associate, and a midwife. The hospital found that 18 (12.7%) had cognitive deficits that could well impair their job performance (no details were provided as to which types of practitioners these were).[6] The 18 clinicians with cognitive impairment voluntarily left their practices or transitioned to closely proctored settings.

In this article the term "clinician" is used when referring to health care providers generally, including non-physicians.

Older clinicians benefit from their many years of experience and the skills they have developed over decades of practice. Many remain valuable and vital members of the health care workforce who are greatly appreciated, especially as the country experiences significant physician and nurse shortages.[7,8] At the same time, however, researchers have raised concerns about performance deficits among older physicians with cognitive impairment.[9]

National and international studies of physicians who were referred to oversight authorities for evaluation because of misconduct or work difficulties reveal that these individuals often have

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cognitive impairment.[10,11,12,13] A Peer Assessment Program in Ontario, Canada found that 22% percent of physicians over 75 years old "had gross deficiencies in their practice," compared to 16% in the 50-to-74 year-old group and 9% of doctors age 49 or younger.[14] An Australian study found that compared to doctors in the 30-60 years old age group, doctors who were over 65 years old had higher rates of notification to medical regulators regarding physical illness, cognitive decline, improper record keeping, illegal use or supply of medications, inadequate certificates and reports, incorrect prescribing, disruptive behavior, and provision of substandard treatment to patients.[15] A study of Medicare patients hospitalized in the United States found that within the same hospital, patients treated by older physician hospitalists had higher mortality rates than those treated by younger hospitalists (though older doctors with high patient volumes did not have elevated mortality rates).[16] Other studies also raise concerns about the cognitive functioning and surgical outcomes of older doctors.[17]

There is also anecdotal evidence that patients have been harmed because of physicians' cognitive infirmities. In one instance, a patient died of a pulmonary embolism due to the negligence of a 78-year-old vascular surgeon with severe cognitive deficits.[18] In another case, a doctor with an aggressive form of dementia exposed himself and committed a sexual act in front of an intellectually disabled patient.[19] A third doctor, who suffered from frontal lobe dementia, carved his initials onto a patient's abdomen during a Cesarean section.[20]

The American College of Surgeons issued a "Statement on the Aging Surgeon" in 2016 that urged surgeons to "voluntarily assess their neurocognitive function using confidential online tools." It further urged surgeons to disclose any worrisome findings to their workplaces.[21]

Some health care institutions have taken matters into their own hands. In addition to Yale New Haven Hospital, Hartford Healthcare, the University of Pittsburgh Medical Center, and several other institutions have implemented "Late Career Practitioner Policies" requiring cognitive testing beginning at a particular age.[22] My recently published article titled "Cognitive Decline and the Workplace" provides an extensive discussion of legal and other barriers that limit the scope of appropriate cognitive testing by employers.[23]

Workers in certain safety-critical jobs are required to retire at particular ages. Examples are firefighters, law enforcement officers, pilots, air traffic controllers, members of the foreign service, and judges in some states.[23] Although clinicians arguably also have safety critical jobs, I do not advocate that they be subject to mandatory retirement policies. That does not mean, however, that concerns about cognitive decline among health care providers should be ignored.

Cognitive Decline and Cognitive Testing

Aging can impact the brain in different ways. When older people's cognitive functioning is compared to mental capacity at the age of 35, it may reveal:

Super aging, in which there is little to no cognitive decline, and mental faculties remain highly functioning even in later ages;

Normal aging, in which there is some decline in cognitive performance, but not so much that it affects daily activity;

Mild cognitive impairment, in which there is accelerated cognitive decline, but not rising to the level of significantly affecting daily life; and

Pathologic aging or dementia, in which there is accelerated cognitive decline that does impair daily functioning.[24]

Approximately 20-25% of seniors have mild cognitive impairment (MCI),[25] and about 15% of MCI patients ultimately experience dementia.[26]

Cognitive decline progresses along a continuum. The well-respected Global Deterioration Scale describes seven stages: 1) no cognitive decline, 2) very mild cognitive decline, 3) mild cognitive decline, 4) moderate cognitive decline, 5) moderately severe cognitive decline, 6) severe cognitive decline, and 7) very severe cognitive decline.[27] Other experts believe that cognitive decline has three to five stages of progression.[28,29]

Many people with cognitive decline or even dementia can continue working for some time.[30] People with Alzheimer's disease, the most common form of dementia, on average, live between 3 and 11 years following diagnosis, but some survive for over 20 years.[29]

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Dementia can adversely affect doctors' job performance because it can cause memory lapses, reduce attention and executive functioning, and erode problem-solving abilities. However, there is no conclusive data regarding how prevalent significant cognitive impairment and diagnosable neurocognitive disorders are among physicians.[9]

There is also no single test that can definitively determine whether an individual has dementia.[31,32] A combination of tools, including medical history, physical and neurological exams, and cognitive testing is often used for diagnostic purposes. Spinal taps, brain imaging, and blood tests can also help diagnose dementia.[33] Thus far, however, no specific testing protocol has proven consistently reliable in assessing or predicting a physician's ability to provide high-quality care. Furthermore, experts have not determined what degree of cognitive impairment endangers patient welfare.[3,34]

Cognitive Testing and the Law

After Yale New Haven Hospital instituted its testing policy for clinicians who were 70 or older, it was sued by the US Equal Employment Opportunity Commission (EEOC), and the litigation is ongoing. The EEOC asserts that the policy constitutes age and disability discrimination.[35]

Under the Age Discrimination in Employment Act (ADEA) it is unlawful for employers "to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age."[36] The EEOC argues that the ADEA prohibits employers from adopting late career practitioner policies that test individuals solely because of their age without regard to whether they exhibit any job performance problems.

The Americans with Disabilities Act (ADA) generally prohibits discrimination against qualified individuals with disabilities.[37] Title I of the ADA, the employment discrimination title, includes a provision that addresses the permissibility of medical inquiries and examinations. It requires that employers restrict testing of employees to that which is "job-related and consistent with business necessity."[38] The EEOC argues that testing employees who show no symptoms of cognitive decline violates the ADA's business necessity provision.

ADEA and ADA Applicability to State Medical Boards

The ADEA does not apply to state medical boards, as it reaches only employment discrimination. Forbidding age discrimination on the part of employers makes sense. Employers are often tempted to discriminate against older workers because of concerns about the cost of health insurance, worries about future productivity and absenteeism problems, and negative stereotypes relating to older individuals.[39] They also may be eager to terminate older employees in order to hire younger individuals who can be paid less.

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By contrast, licensing boards do not need to worry about their own profitability and are tasked with focusing on public welfare. Therefore, they do not have a history of age discrimination that justifies a statutory ban.

Other licensing entities with public safety responsibilities have instituted special requirements for older individuals, particularly with respect to driving. Thirty-one states and the District of Columbia mandate increased renewal frequency, renewal in person, and vision tests. The District of Columbia and Nevada require medical certification after age 70, and Illinois requires a road test for those 75 or older.[40] These requirements do not violate any age discrimination statute.

Unlike the ADEA, the ADA does apply to state medical boards. State medical boards are state entities that grant licenses to physicians and are therefore public entities, covered by Title II of the ADA.[41,42] Federal regulations establish that

> "A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability.[43]

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Another relevant regulatory provision is the following:

> "A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."[44]

In addition to prohibiting disability-based discrimination, this Title requires "reasonable modifications to rules, policies, or practices," to enable qualified individuals with disabilities to participate in "programs or activities provided by a public entity."[45] At the same time, public entities need not provide accommodations that would impose undue hardships on them, and they are permitted to establish safety requirements based on actual safety risks.[46]

Title I's restrictions on medical queries and examinations do not apply to state medical boards because they are not employers. A reasonable interpretation of Title II of the ADA is that licensing boards should restrict their queries to those that focus on a clinician's current ability to perform work safely and effectively. It follows that state licensing boards should not ask applicants about temporary, past cognitive problems that have been resolved. However, they are permitted to investigate whether applicants have current cognitive deficits that could impair job performance.[47]

Contemporary Medical Licensing, Renewal, and Disciplinary Actions

In order to be fully licensed by state medical boards, applicants must meet many requirements, including educational attainments, passing medical licensing examinations, undergoing medical background checks, and more. In addition, guidelines adopted by the Federation of State Medical Boards provide that "[t]he applicant should not be currently suffering from any condition for which they are not being appropriately treated that impairs their judgement or that would otherwise adversely affect their ability to practice medicine in a competent, ethical, and professional manner."[48] Consequently, the vast majority of medical boards ask questions about cognitive health for purposes of initial medical licensing.[47]

Cognitive decline is unlikely to be present when doctors are initially licensed. It is much more likely to emerge decades into physicians' careers, when they need only renew their licenses.

Understandably, the requirements for license renewal are far less extensive. In all states, physicians can renew their licenses online.[49] According to the Federation of State Medical Boards' guidelines, boards may require continuing medical education for renewal purposes and should ask licensees to self-report disciplinary actions, findings of malpractice liability, and other matters of concern. One such item is "[w]hether the licensee is currently suffering from any condition for which they are not being appropriately treated that impairs their judgment or that would otherwise adversely affect their ability to practice medicine in a competent, ethical and professional manner."[48]

In the case of cognitive decline, individuals themselves may not recognize that they suffer from the condition. An additional safeguard is thus reporting by colleagues. According to the Federation of State Medical Boards' guidelines, a variety of parties, including all licensed health care providers, should be required to report to the board "in writing any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine."[48] Most states in fact require licensees to report colleague's misconduct or incompetence and threaten license revocation and substantial fines for those who fail to report such information.[50,51]

Despite these potential penalties, physicians are often reluctant to report incompetence or impairment on the part of their colleagues. In 2009, a national survey with 1,891 participants (64.4% response rate) found that only 67% of doctors who had direct knowledge of a colleague's incompetence reported the matter.[52] A study published in 2007 found that only 55% of physicians who encountered impaired or incompetent colleagues reported them to authorities.[53]

A 2021 report by the Public Citizen's Health Research Group found very low rates of serious disciplinary action against physicians during the years 2017-2019. It argued that "many, if not most, state medical boards are doing a dangerously lax job in enforcing their states' medical practice acts."[54] The study found that the rate of serious disciplinary actions per 1,000 physicians per year ranged from 2.29 in Kentucky to 0.29 in the

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District of Columbia. The authors believed that these distinctions were attributable to differences in the performance of state medical boards, not meaningful differences in the levels of competence or misconduct among physicians in different states. These statistics suggest that state medical boards are not successfully identifying and engaging with all physicians who are endangering patients because of cognitive impairment.

One reason for this is that the disciplinary work of medical boards in the United States is reactive in nature. They receive complaints and then investigate and address them. However, they do not launch investigations on their own initiative in the absence of submitted complaints.[55]

When they do discover misconduct or incompetence, medical boards are empowered to take disciplinary action. For example, they are authorized to do so if a doctor is found to be "mentally unable to engage in the practice of medicine with reasonable skill and safety."[48] State medical practice acts provide procedural safeguards, such as notice, a hearing, an opportunity for representation, and judicial review, to ensure due process and fairness for licensees. Procedural safeguards, however, vary among the states.[56]

State Medical Boards: A Way Forward

Cognitive decline is difficult to discern but can significantly endanger patient welfare. The current approach of relying on physicians' self-reporting or reporting by colleagues is inadequate.[9] Individuals are often unaware of their own cognitive decline. They may also misjudge the extent of their impairment or simply wish to hide it because of a desire to keep their jobs. Practitioners are also often unwilling to report their colleagues.[1] Moreover, in the case of cognitive impairment, colleagues may be uncertain as to whether they are observing a chronic problem or just a temporary manifestation of fatigue or stress. Many physicians have performance deficiencies because of burnout rather than cognitive decline.[57]

Leaving identification of cognitive decline to health care entities through a broad testing program is also a problematic approach. First, many physicians work in physician-owned practices and are not employees of health care organizations.[58] Thus they are not subject to routine oversight by supervisors or managers.

Second, when acting as employers, health care organizations may lack the expertise to select appropriate cognitive tests, interpret test results correctly, and determine what action, if any, is appropriate. They also may be motivated to overreact to suboptimal test scores because of concern about their own profitability or liability. The same is true for hospitals that are assessing clinicians who are not technically their employees for purposes of renewing their staff privileges.

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Third, employers risk running afoul of the ADA and ADEA along with state anti-discrimination laws.[59] As noted above, Yale New Haven Hospital has been sued by the EEOC because of its Late Career Practitioner Policy. Stanford University Medical Center abandoned its cognitive testing requirement in 2012 after intense lobbying by its physicians, though it still administers physical testing and peer review beginning at age 75.[60] In lieu of administering age-based cognitive testing, employers should regularly assess the work of all employees regardless of age and should require testing only of individuals who demonstrate performance deficits that suggest cognitive decline.[23]

Given the shortcomings of reporting and employer late career practitioner policies, state licensing boards appear to be the best choice for systematically addressing concerns about cognitive decline in the health care workforce. State boards face fewer legal barriers to implementing age-based testing programs than employers face. In addition, they should not have any agenda beyond patient safety because, unlike employers and credentialing institutions, they are not concerned about their own liability and income.

Medical licensing boards are not governed by the ADEA. Because licensing boards are state entities, opponents of late career testing policies might allege age discrimination in violation of the Equal Protection Clause. However, constitutional age discrimination claims would be subject to rational basis analysis, under which the government must prove only that its actions are rationally related to a legitimate government interest (e.g., patient welfare).[61] Age-based Equal Protection claims are generally doomed to fail.[62]

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Some form of proactive cognitive testing for older health care providers is well worth considering. According to the Federation of State Medical Boards Guidelines, boards "should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care."[48] While some state laws allow medical boards to establish renewal criteria as they see fit,[63] other, less flexible statutes may need to be modified to allow explicitly for late career cognitive testing.[64]

The US would not be alone in requiring its older doctors to undergo special evaluations for license renewal purposes. Several Canadian provinces have already adopted this approach. For example, in Ontario, physicians who reach age 70 undergo peer and practice assessments, which are performed every five years thereafter so long as the doctor continues to practice.[65] In Manitoba, physicians, clinical assistants, and physician assistants must participate in an audit upon reaching age 75 to determine their professional competence.[66] In British Columbia, physicians over the age of 70 are prioritized for a physician assessment every three to five years.[67]

Testing programs should apply to all licensed health care providers, not just physicians. They thus should be adopted not only by state medical boards, but by all state licensing boards that oversee health care providers.

As required by the ADA, any testing program would need to be narrowly tailored to evaluate whether at-risk clinicians currently have cognitive deficits that can impair job performance. It would also need to include efforts to provide clinicians with reasonable accommodations to facilitate job performance. In addition, clinicians must have due process protections, and no program should be instituted without general support from the health care community.

Late Career Testing Program Framework

Identify or Create Appropriate Testing Tools

An ideal screening policy may be a peer and practice assessment program for older clinicians, such as those implemented in Canada.[65,66,67] However, state licensing boards in the United States are unlikely to adopt policies that require thorough, individualized evaluation of all older clinicians because of staffing and funding constraints.[54] Consequently, an efficient testing program is more realistic, though it too would likely require increased budgets and larger staffs.

In order to devise a testing protocol, experts must determine whether there are appropriate cognitive testing tools with which to screen physicians and other health care providers. No consensus exists concerning which tests are optimal.[3] To comply with the ADA, testing would need to be designed to identify those who are at risk of current job-performance problems.

It is possible that entirely new tests that do not yet exist will need to be created. In addition, several alternative tests may need to be used or developed because of differences in the skills required for various types of practice.

Rather than cognitive testing, experts may choose to require tests of basic substantive knowledge. Physicians who have specialty board certification are generally required to undergo periodic assessment to maintain their certifications.[68] These can consist of examinations, modules that require analysis of hypothetical cases, and open book online quizzes.[69] For example, in 2022 the American Board of Internal Medicine launched a longitudinal assessment program through which physicians answer 500 questions over a 5-year period.[70] Test designers could adopt a quiz or module-based approach to verify that older physicians are sufficiently competent, and they could allow those who have been recently examined for certification purposes to submit their results in lieu of new testing.

Experts would also need to determine at which age testing should begin and how frequently it should be administered. Employer testing programs often commence at age 70 or 75.[17] Testing could be required each time older clinicians renew their licenses.

Preliminary screening should not be cumbersome. Whichever test or tests is selected and validated for health care providers could be administered online with appropriate safeguards to prevent testing misconduct and maintain confidentiality. If initial testing scores raise concerns, further investigation would need to follow. This could consist of more comprehensive cognitive testing, review of clinical performance, interviews with colleagues, and other measures.

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Due Process and Reasonable Accommodation

If a board determines that an individual is cognitively impaired, it must implement all procedural safeguards that would apply in any disciplinary case. For example, clinicians should be entitled to representation and a hearing to try to prove that they remain able to perform their work competently. In some cases, clinicians may be able to prove that their cognitive impairment resulted from another condition such as hearing loss or hypothyroidism and that medication or a remedial device has resolved the problem.

Wherever possible, boards should require remedial measures as reasonable accommodations rather than license suspension. Ideally, cognitive screening should help some clinicians prolong their careers by enabling them to work comfortably and safely and to avoid catastrophic mistakes. For example, clinicians may use memory aids, switch to a part-time schedule, or restrict their practices. To illustrate, an ophthalmologist might stop performing surgery but continue to examine patients with the help of technicians who conduct routine tests. Boards may choose to refer licensees to specialized assessment programs to determine whether there are feasible accommodations. One resource, the Physician Assessment and Clinical Education (PACE) Program, run by the UC San Diego School of Medicine, asserts that it is the "largest assessment and remediation program for healthcare professionals in the country" and has served over 2000 health care professionals.[71]

If no accommodation is possible, the clinician should not be permitted to continue working. State boards must act without delay after due process requirements have been met and reasonable accommodation efforts have failed. Patient safety must be the boards' top priority.

Clinician Buy-In

Clear communication and education would be vital for the success of any late career testing program. Ideally, older clinicians will accept that testing is not meant to be a punitive measure but, rather a reasonable mechanism to safeguard the welfare of both medical professionals and patients. Moreover, satisfactory test scores may reassure clinicians about their cognitive capacities and protect them from accusations of mental decline.

Admittedly, achieving widespread acceptance of a testing program will be an uphill battle. The country is facing significant physician shortages,[7] and it would be imprudent to institute a policy that would induce capable physicians to retire prematurely because of resentment or alienation. Other barriers exist as well.

In 2018 The American Medical Association (AMA) proposed eight guiding principles "as a basis for developing guidelines for the screening and assessment of senior/later career physicians."[72] The AMA opposed "written examination[s] of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination." Even so, the proposal was voted down in large part because of concern about ageism.[73]

At the state level, Utah prohibits employers and licensing boards from requiring physicians to undergo age-based cognitive testing unless ten conditions are met. One of these conditions is that the screening must be "based on evidence of cognitive changes associated with aging that are relevant to physician performance."[74] This would seem to preclude a general testing program, and the law would need to be amended to adopt a testing protocol.

Despite resistance from the medical community, it is irresponsible to ignore the reality that a growing number of physicians are aging and at risk of suffering cognitive decline that could affect their job performance. Patients put their lives in the hands of health care providers every day, and an effective oversight system must do its utmost to safeguard their welfare. State medical boards are well positioned to screen and identify physicians with cognitive deficits.

DESPITE RESISTANCE FROM THE MEDICAL COMMUNITY, IT IS IRRESPONSIBLE TO IGNORE THE REALITY THAT A GROWING NUMBER OF PHYSICIANS ARE AGING AND AT RISK OF SUFFERING COGNITIVE DECLINE THAT COULD AFFECT THEIR JOB PERFORMANCE.

If cognitive testing of older physicians is thoughtful, validated, and not very cumbersome, it could

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become a routine part of license renewal whose value is recognized. Dedicated professionals do not want to end their careers with catastrophic mistakes that could have been prevented with proper intervention. Continuing education and robust advocacy may lead late career clinicians to accept if not embrace the opportunity to be periodically screened.

Conclusion

Older physicians and other medical professionals can bring a wealth of experience and finely honed skills to their jobs. Most often they make invaluable contributions to patient care and serve as mentors and role models for many. But concerns about cognitive decline among seniors who are health care providers cannot be disregarded.

Because of the pitfalls of self-reporting, peer reporting, and employer testing, state licensing boards may be in the best position to implement screening programs. Such programs cannot be adopted immediately, as they must be carefully developed. Experts must formulate an appropriate testing protocol and determine at what age it should commence. Ideally, a carefully designed testing program would be adopted in all states for the sake of national uniformity and would be supported by professional organizations such as the AMA. Testing should be accompanied by due process safeguards and reasonable accommodations.

State licensing boards should make every effort to balance the interests of clinicians, health care employers, and the patients they serve. To do so, they must tackle the challenges of cognitive decline in a manner that gains the trust and assent of all stakeholders.

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References

1. Powell T. OK, Boomer, MD: The Rights of Aging Physicians and the Health of Our Communities. *Hastings Cent Rep*. 2020;50(6):3. doi: 10.1002/hast.1191
2. Michas F. Total Number of Active Physicians in the US, as of September 2021, by State. October 19, 2021. https://www.statista.com/statistics/186269/total-active-physicians-in-the-us/.
3. Armstrong KA, Reynolds EE. Opportunities and Challenges in Valuing and Evaluating Aging Physicians. *JAMA*. 2020;323(2):125-26. doi: 10.1001/jama.2019.19706
4. Causes and Risk Factors for Alzheimer's Disease. Accessed June 30, 2022. https://www.alz.org/alzheimers-dementia/what-is-alzheimers/causes-and-risk-factors.
5. Carbajal E. Viewpoint: 5 Strategies to Address Cognitive Impairment among Aging Physicians. *Becker's Hosp. Rev.* April 21, 2021. Accessed June 30, 2022. https://www.beckershospitalreview.com/hospital-physician-relationships/viewpoint-5-strategies-to-address-cognitive-impairment-among-aging-physicians.html.
6. Cooney L, Balcezak T. Cognitive Testing of Older Clinicians Prior to Recredentialing. *JAMA*. 2020;323(2):179-80. doi: 10.1001/jama.2019.18665
7. AAMC Report Reinforces Mounting Physician Shortage. News Release. Association of American Medical Colleges; June 11, 2021. Accessed June 30, 2022. https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage.
8. Behring S. Understanding the American Nursing Shortage. Healthline. August 11, 2021. Accessed June 30, 2022. https://www.healthline.com/health/nursing-shortage#takeaway.
9. Soonsawat A, Tanaka G, Lammando MA, Ahmed I, Ellison JM. Cognitively Impaired Physicians: How Do We Detect Them? How Do We Assist Them? *AmJ Geriatric Psychiatry*. 2018;26(6):631-640. doi: 10.1016/j.jagp.2018.01.203
10. Pesiah C, Wilhelm K. Physicians Don't Heal Thyself: A Descriptive Study of Impaired Older Doctors. *Int Psychogeriatr*. 2007;19(5):974-984. doi: 10.1017/S1041610207005431
11. Turnball J, Carbotte R, Hanna E, et al. Cognitive Difficulty in Physicians. *Acad Med*. 2000;75(2)177-181. doi: 10.1097/00001888-200002000-00018
12. Perry W, Crean R. A Retrospective Review of the Neuropsychological Test Performance of Physicians Referred for Medical Infractions. *Arch Cli. Neuropsychol*. 2005;20(2):161-170. doi: 10.1016/j.acn.2004.04.002
13. Korinek LL, Thompson LL, McRac C, Korinek E. Do Physicians Referred for Competency Evaluations Have Underlying Cognitive Problems? *Acad Med* 2009;84(8):1015-1021. doi: 10.1097/ACM.0b013e3181ad00a2
14. Moutier CY, Bazzo DEJ, Norcross WA. Approaching the Issue of the Aging Physician Population. *JMed. Reg* 2013;99(1):10–18. doi: 10.30770/2572-1852-99.1.10
15. Thomas LA, Milligan E, Tibble H, et al. Health, Performance and Conduct Concerns among Older Doctors: A Retrospective Cohort Study of Notifications Received by Medical Regulators in Australia. *J of Patient Safety & Risk Management*. 2018;23(2):54-62. doi: 10.1177/2516043518763181

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16. Tsugawa Y, Newhouse JP, Zaslavsky AM, Blumenthal DM, Jena AB. Physician Age and Outcomes in Elderly Patients in Hospital in the US: Observational Study. *BMJ*. 2017;357:j1797. doi: 10.1136/bmj.j1797
17. California Public Protection and Physician Health, Inc. Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening. 2015. Accessed June 30, 2022. https://www.procopio.com/uploads/model/Block/4698/pdf/256/assessing-late-career-practitioners-policies-and-procedures-for-age-based-screening-3176.pdf
18. Tarkan L. As Doctors Age, Worries About Their Ability Grow. *New York Times*. January 24, 2011. Accessed June 30, 2022. https://www.nytimes.com/2011/01/25/health/25doctors.html.
19. Jane Doe v. Mohan Sharma, M.D., Hita Sharma, M.D., Caring Med., LLC, 2018 N.Y. Slip Op. 28386 (N.Y. Sup. Ct. 2018)
20. Wong E. Doctor Carved His Initials into Patient, Lawsuit Says. *New York Times*. June 30, 2022. Accessed Jun3 30, 2022. https://www.nytimes.com/2000/01/22/nyregion/doctor-carved-his-initials-into-patient-lawsuit-says.html.
21. American College of Surgeons. Statement on the Aging Surgeon. January 1, 2016. Accessed June 30, 2022. https://www.facs.org/about-acs/statements/80-aging-surgeon.
22. Katlic MR, Coleman J. Balancing Safety with Dignity When Evaluating Aging Practitioners. American Association for Physician Leadership. March 1, 2018. Accessed June 30, 2022. https://www.physicianleaders.org/news/balancing-safety-with-dignity-when-evaluating-aging-practitioners
23. Hoffman S. Cognitive Decline and the Workplace. *Wake Forest L Rev* 2022; 57(1):115-72. Accessed July 1, 2022. https://scholarlycommons.law.case.edu/faculty_publications/2121/
24. Shen FX. Aging Judges. *Ohio State L J*. 2020;81(2):235-314. Accessed June 30, 2022. https://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1671&context=faculty_articles
25. Graham J. Research Shows that the Prevalence of Dementia Has Fallen in the United States. *Washington Post*. June 16, 2018. Accessed June 30, 2022. https://www.washingtonpost.com/national/health-science/research-shows-that-the-prevalence-of-dementia-has-fallen-in-the-united-states/2018/06/15/636d61ac-6fd1-11e8-bf86-a2351b5ece99_story.html.
26. Harvard Medical School. Staving off Dementia when You Have Mild Cognitive Impairment. *Harv. Health Pub*. March 30, 2021. Accessed June 30, 2022. https://www.health.harvard.edu/staying-healthy/staving-off-dementia-when-you-have-mild-cognitive-impairment.
27. Reisberg B, Ferris SH, de Leon MJ, Crook T. The Global Deterioration Scale for Assessment of Primary Degenerative Dementia, *Am J Psychiatry*. 1982;139(9):1136-9. doi: 10.1176/ajp.139.9.1136
28. Stages of Alzheimer's. Accessed June 30, 2022. https://www.alz.org/alzheimers-dementia/stages
29. Alzheimer's Stages: How the Disease Progresses. Accessed June 30, 2022. https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/alzheimers-stages/art-20048448.
30. Silvaggi F, Leonardi M, Tiraboschi P, Muscio C, Toppo C, Raggi A. Keeping People with Dementia or Mild Cognitive Impairment in Employment: A Literature Review on Its Determinants. *Int J Environ*. *Res Public Health*. 2020;17(3):842. doi: 10.3390/ijerph17030842
31. Medical Tests for Diagnosing Alzheimer's. Accessed June 30, 2022. https://www.alz.org/alzheimers-dementia/diagnosis/medical_tests.
32. Dementia. Accessed June 30, 2022. https://www.mayoclinic.org/diseases-conditions/dementia/diagnosis-treatment/drc-20352019.
33. Landhuis E. Detecting Alzheimer's Gets Easier with a Simple Blood Test. *Scientific American*. February 4, 2021. Accessed June 30, 2022. https://www.scientificamerican.com/article/detecting-alzheimers-gets-easier-with-a-simple-blood-test/.
34. AMA Council on Medical Education. Report 1 of the Council on Medical Education. Accessed June 30, 2022. https://services.aap.org/globalassets/sonpm/wecan/sonpm–wecanseniorphysicianscompetency.pdf
35. EEOC Sues Yale New Haven Hospital for Age and Disability Discrimination. News Release. US Equal Employment Opportunity Commission. February 11, 2020. Accessed June 30, 2022. https://www.eeoc.gov/newsroom/eeoc-sues-yale-new-haven-hospital-age-and-disability-discrimination.
36. Prohibition of Age Discrimination. 29 US. § 623 (2011). Accessed June 30, 2022. http://www. https://www.govinfo.gov/app/details/USCODE-2011-title29/USCODE-2011-title29-chap14-sec623.
37. Discrimination. 42 USC §12132 (1990). Accessed June 30, 2022. https://www.govinfo.gov/content/pkg/USCODE-2020-title42/pdf/USCODE-2020-title42-chap126-subchapII-partA-sec12132.pdf.
38. Discrimination. 42 USC.§12112(d)(4)(A) (1990). Accessed June 30, 2022. https://www.govregs.com/uscode/expand/title42_chapter126_subchapterI_section12112#uscode_1
39. 29 USC. § 621 (2018)
40. Insurance Institute for Highway Safety, Highway Loss Data Institute. License Renewal Procedures by State. January 2022. Accessed June 30, 2022. https://www.iihs.org/topics/older-drivers/license-renewal-laws-table.
42. Public Entity. 42 USC. §12131(1)(1990). Accessed June 30, 2022. https://www.govinfo.gov/content/pkg/USCODE-2020-title42/pdf/USCODE-2020-title42-chap126-subchapII-partA-sec12131.pdf
42. Schroeder R, Brazeau CMLR, Zackin F, et al. Do State Medical Board Applications Violate the Americans with Disabilities Act? *Acad. Med*. 2009;84(6):776–781. doi: 10.1097/ACM.0b013e3181a43bb2
43. General Prohibitions Against Discrimination. 28 CFR §35.130(b)(6)(2008). Accessed June 30, 2022. https://www.govinfo.gov/app/details/CFR-2008-title28-vol1/CFR-2008-title28-vol1-sec35-130.
44. Nondiscrimination on the Basis of Disability in State and Local Government Services. 28 CFR §35.130(b)(8) (2008). Accessed June 30, 2022. https://www.govinfo.gov/app/details/CFR-2008-title28-vol1/CFR-2008-title28-vol1-sec35-130.
45. Definitions-Qualified Individual with a Disability. 42 USC §12131(2) (1990). Accessed June 30, 2022. https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap126-subchapII-partA-sec12131.pdf.

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46. General Prohibitions Against Discrimination-Nondiscrimination on the Basis of Disability in State and Local Government Services. 28 CFR §§35.130(b)(7)(i) and (h) (2008). Accessed June 30, 2022. https://www.govinfo.gov/app/details/CFR-2008-title28-vol1/CFR-2008-title28-vol1-sec35-130.
47. Jones JTR, North CS, Vogel-Scibilia S, Myers MF, Owen RR. Medical Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act. *J Am Acad Psychiatry Law*. 2018;46(4):458-471. doi: 10.29158/JAAPL.003789-18
48. Guidelines for the Structure and Function of a State Medical and Osteopathic Board. May 2021. Accessed June 30, 2022. https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf.
49. Doctor of Medicine Renewal. Accessed June 30, 2022. https://med.ohio.gov/Renew/Physician/Physician-MD-DO-DPM.
50. Civil Penalty. OH Rev Code §4731.225 (2017). Accessed June 30, 2022. https://codes.ohio.gov/ohio-revised-code/section-4731.225.
51. New CME Requirement on the Duty to Report. June 1, 2021. Accessed June 30, 2022. https://med.ohio.gov/Publications/Recent-News/new-duty-to-report-webpage.
52. DesRoches CM, Rao SR, Fromson JA., et al. Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues. *JAMA*. 2010;304(2):187-193. doi: 10.1001/jama.2010.921
53. Campbell EG, Regan S, Gruen RL, et al. Professionalism in Medicine: Results of a National Survey of Physicians. *Ann Intern Med*. 2007;147(11):795-802. doi: 10.7326/0003-4819-147-11-200712040-00012
54. Wolfe S, Oshel RE. Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2017-2019. *Public Citizen*. March 31, 2021. Accessed June 30, 2022. https://www.citizen.org/wp-content/uploads/2574.pdf.
55. Landess J. State Medical Boards, Licensure, and Discipline in the United States. Focus (Am Psychiatr Publ). 2019;17(4):337–342. doi: 10.1176/appi.focus.20190020
56. Murphy AM. Preponderance, Plus: The Procedure Due to Professional Licensees in State Revocation Hearings. *Connecticut Law Review*. 2020;52(2):943-987. Accessed June 30, 2022. https://opencommons.uconn.edu/law_review/433.
57. Hoffman S. Healing the Healers: Legal Remedies for Physician Burnout. *Yale Journal of Health Policy Law and Ethics*. 2018;18(2):56-113. Accessed June 30, 2022. https://openyls.law.yale.edu/handle/20.500.13051/5952.
58. AMA Analysis Shows Most Physicians Work Outside of Private Practice. News Release. AMA. May 5, 2021. Accessed June 30, 2022. https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice.
59. Moore IN. Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory? *Health Matrix.* 2018;28(1):95-196. Accessed June 30, 2022. https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1629&context=healthmatrix.
60. Katlic MR, Coleman J. Balancing Safety with Dignity When Evaluating Aging Practitioners. American Association for Physician Leadership. March 1, 2018. Accessed June 30, 2022. https://www.physicianleaders.org/news/balancing-safety-with-dignity-when-evaluating-aging-practitioners.
61. *Levin v. Madigan*, 692 F.3d 607, 619 (7th Cir. 2012).
62. Kohn NA. Rethinking the Constitutionality of Age Discrimination: A Challenge to a Decades-Old Consensus. UC Davis L. Rev. 2010;44(1):213-283, 216.
63. MD Health Occ Code § 14-316 (2013).
64. OK Stat. 59-2037 (2021).
65. Assessments. College of Physicians and Surgeons of Ontario. 2021. Accessed June 30, 2022. https://www.cpso.on.ca/en/Physicians/Your-Practice/Quality-Management/Assessments
66. Age Triggered Quality Audit. The College of Physicians & Surgeons of Manitoba. December 9, 2020. Accessed June 30, 2022. https://cpsm.mb.ca/assets/Policies/Age%20Triggered%20Quality%20Audit%20Policy.pdf.
67. Physician Assessments. College of Physicians and Surgeons of British Columbia. Accessed June 30, 2022. https://www.cpsbc.ca/registrants/programs/ppep/physician-assessments.
68. ABMS Board Certification Report 2020-2021. Accessed June 30, 2022. https://www.abms.org/wp-content/uploads/2022/01/ABMS-Board-Certification-Report-2020-2021.pdf.
69. Family Medicine Certification Longitudinal Assessment. Accessed June 30, 2022. https://www.theabfm.org/continue-certification/cognitive-expertise/FMCLA.
70. Hessel M. Everything You Need to Know About The ABIM Longitudinal Assessment. MedStudy. April 23, 2021. Accessed June 30, 2022. https://explore.medstudy.com/blog/everything-you-need-to-know-abim-longitudinal-assessment.
71. UC San Diego School of Medicine. Physician Assessment and Clinical Education (PACE). Accessed June 30, 2022. http://www.paceprogram.ucsd.edu/.
72. AMA Council on Medical Education. Report 1 of the Council on Medical Education. (2018). Accessed June 30, 2022. https://services.aap.org/globalassets/sonpm/wecan/sonpm–wecanseniorphysicianscompetency.pdf.
73. Gleason PW. Physician Assessments: Ageist or Necessary? *Psychiatric Times*. Apr. 5, 2021. Accessed June 30, 2022. https://www.psychiatrictimes.com/view/physician-assessments-ageist-necessary.
74. Qualifications for Licensure. UT St. § 58-67-302(5)(b)(i) (2020). Accessed June 30, 2022. https://le.utah.gov/xcode/Title58/Chapter67/58-67-S302.html?v=C58-67-S302_2018050820180508.

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