THROWING IN THE TOWEL (LITERALLY): THE RISKS OF AGING SURGEONS AND WHY INDIVIDUALIZED MEDICAL TESTING IS THE BEST SOLUTION

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Medical incompetence and its legal ramifications are a serious concern for patients and surgeons alike. Because of the inevitable decline in physical and cognitive abilities in the elderly, the risk of adverse outcomes from medical incompetence increases as a surgeon ages. Unfortunately, the safeguards in place to prevent adverse outcomes due to aging surgeons are weak and inefficient. The primary mechanisms to protect against adverse outcomes is self- or peer-reporting. Yet, these mechanisms are rarely used. Some high-risk professionals, such as airline pilots, are subject to regulations as they age such as performance-based medical testing. Other professions even have mandatory retirement ages. The medical profession, however, has historically opposed any type of regulation, preferring instead to self-police. But with an increasingly aged population of surgeons, patients and employers are rightfully becoming more concerned about the problem of aging surgeons. This Note recommends a solution that balances the interests of patient-protection, employer cost, and surgeon dignity. Analyzing policy considerations under relevant laws such as the Age Discrimination in Employment Act and the Americans with Disabilities Act, this Note advocates that individualized physical and cognitive testing for surgeons over age sixty-five is a fair solution for all.

I. INTRODUCTION

Undergoing surgery can be scary for anyone. For some, the primary fear is going under and never waking back up. Although most people will never see this fear come true, not everyone is so fortunate.

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At a major Midwestern hospital, a patient tragically bled out on the operating table during a routine gallbladder operation.[1] When the hospital investigated the death, it found that for years, Dr. Doe, the attending surgeon, had been notorious for surgeries that were "abnormally bloody."[2] In fact, for the past six years, the clerks that scheduled Dr. Doe's surgeries would routinely order extra blood bags to the operating room because they anticipated the surgical patient's need for a blood transfusion.[3] The anesthesia department would schedule the most expert anesthesiologists for Dr. Doe's surgeries to compensate for the increased surgical risk.[4] The problem was twofold. For one, Dr. Doe was an elderly surgeon; he never transitioned his procedures from open-abdominal surgery to the newer, less invasive laparoscopic surgery.[5] Secondly, when younger medical staff saw Dr. Doe struggling, their reverence for Dr. Doe, along with their "snitch guilt,"[6] kept them from reporting.[7]

While many surgeons can practice with expertise and competency well into their eighties and nineties,[8] others succumb to the cognitive and physical declines that are inevitable with aging.[9] Yet, unlike consumer safeguards in other high-stakes professions such as federal law enforcement and airline pilots,[10] there are no adequate safeguards to protect against the aging surgeon.[11]

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1. Ralph B. Blasier, *The Problem of the Aging Surgeon When Surgeon Age Becomes a Surgical Risk Factor*, 467 CLINICAL ORTHOPAEDICS & RELATED RSCH., 402, 402 (Oct. 31, 2008).
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. Jennifer Adaeze Okwerekwu, *An elderly doctor was struggling. I spoke up. Then came the 'snitch guilt.'*, STAT NEWS (Nov. 8, 2017), https://news.yahoo.com/elderly-doctor-struggling-spoke-then-093039315.html.
7. Blasier, *supra* note 1.
8. Stacey Burling, *More doctors are practicing past age 70. Is that safe for patients?*, PHILA. INQUIRER (Sept. 8, 2017), https://www.inquirer.com/philly/health/health-news/more-physicans-are-practicing-past-age-70-is-that-safe-for-patients-20170908.html; Associated Press, *World's Oldest Practicing Doctor Dies at 114*, FOX NEWS, https://www.foxnews.com/health/worlds-oldest-practicing-physican-dies-at-114 (last updated Oct. 27, 2015).
9. Blasier, *supra* note 1.
10. KATELIN P. ISAACS, CONG. RSCH. SERV., R42631, RETIREMENT BENEFITS FOR FEDERAL LAW ENFORCEMENT PERSONNEL 4 (2017); Fair Treatment for Experienced Pilots Act, Pub. L. No. 110-135, 121 Stat. 1450 (2007).
11. Barbara Grandjean & Chad Grell, *Why No Mandatory Retirement Age Exists for Physicians: Important Lessons for Employers*, 116 MO. MED. 357, 357 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6797044/.

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This Note argues that there should be state laws in place that strike a balance between patient safety and liability issues and a physician's desire to have autonomy and dignity over his or her practice. Part II reviews the need for such a law by discussing specific safety concerns and legal liabilities posed by aging surgeons. Part III analyzes options for lawmakers and employers such as individual medical testing and mandatory retirement ages, and the respective legal challenges under the Age Discrimination in Employment Act ("ADEA") and the Americans with Disabilities Act ("ADA"). Part III also discusses federal legislation that addresses the aging workforce in other high-stakes professions such as airline pilots. Additionally, Part III includes other factors that lawmakers and employers must consider when crafting policies addressing aging surgeons. Finally, Part IV recommends a policy that balances the interests of patients, healthcare systems, and aging surgeons.

II. Background

A. Medical Malpractice Concerns

When a patient is injured due to negligent treatment by their physician, the physician and his or her respective employer may be liable for medical malpractice.[12] Litigating medical malpractice claims can be extremely costly for both physicians and their employers.[13] While these claims are a serious concern for physicians of any age in any specialty, older physicians have a higher incidence of medical malpractice claims than younger physicians.[14] One study in the New England Journal of Medicine found that eighty percent of physicians in surgical specialties, including general surgery, were projected to face a claim by age forty-five.[15] The same study also found that by age sixty-five, ninety-nine percent of physicians in "high-risk specialties" had faced a malpractice

12. *What is Medical Malpractice?*, AM. BD. PRO. LIAB. ATT'YS, https://www.abpla.org/what-is-malpractice (last visited Oct. 21, 2021).

13. *Id.*

14. José R. Guardado, *Policy Research Perspectives Medical Liability Claim Frequency Among U.S. Physicians*, AM. MED. ASS'N 6 (Dec. 2017) https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-medical-liability-claim-frequency.pdf.

15. Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW. ENG. J. MED. 629, 633 (2011).

claim.[16] One likely culprit for the higher incidence of medical malpractice claims is the cognitive and physical decline associated with aging, particularly for functions necessary to perform surgery.[17] In addition, technological advances in medicine make it increasingly difficult for elderly surgeons to adapt to new, safer practices.[18]

1. COGNITIVE AND PHYSICAL DECLINE

Cognitive and physical decline is an unfortunate side effect of aging that does not stop to spare those who diagnose and treat our illnesses.[19] There is a robust body of medical literature documenting the cognitive and physical declines of physicians.[20] And while much attention is given to age-related disease processes such as dementia and Parkinson's disease, the majority of adults over the age of sixty-five will not develop these diseases.[21] Instead, most people will experience the effects of normal cognitive aging, which are less understood and more loosely defined.[22] Additionally, the prevalence of physical impairments in adults over sixty-five years of age is already widespread and is projected to increase.[23] For example, from 2013-2015, 22.7% of the United States population reported having doctor-diagnosed arthritis, including 49.6% of people aged sixty-five years or older.[24] By 2040, the general incidence of arthritis among adults in the United States is projected to increase from 22.7% to 26%, or an additional 26.6 million people.[25]

The number of aging physicians is increasing as well.[26] According to the American Medical Association's ("AMA") 2015 Report on

16. *Id.*
17. *See* Blasier, *supra* note 1.
18. Blasier, *supra* note 1; Kate Conger & Erin Griffith, *As Life Moves Online, an Older Generation Faces a Digital Divide*, N.Y. TIMES, https://www.nytimes.com/2020/03/27/technology/virus-older-generation-digital-divide.html (Mar. 28, 2020).
19. Caroline N. Harada et al., *Normal Cognitive Aging*, 29 CLINICAL GERIATRIC MED. 737, 737–752 (2013).
20. *See* Blasier, *supra* note 1; *Competency and retirement: Evaluating the senior physician*, AM. MED. ASS'N (June 23, 2015) [hereinafter *Competency and retirement*], https://www.ama-assn.org/practice-management/physician-diversity/competency-and-retirement-evaluating-senior-physician.
21. Harada, *supra* note 19; *Parkinson's Disease*, NAT'L INST. ON AGING (May 16, 2017), https://www.nia.nih.gov/health/parkinsons-disease#.
22. Harada, *supra* note 19.
23. *Arthritis Related Statistics*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 18, 2018), https://www.cdc.gov/arthritis/data_statistics/arthritis-related-stats.htm.
24. *Id.*
25. *Id.*
26. THE COUNCIL ON MED. EDU., *Competency and the Aging Physician*, AM. MED. ASS'N 5-A-15 (2015) [hereinafter AMA 2015 Report], https://www.cppph.org/wp-

Competency and the Aging Physician, "[t]he total number of physicians sixty-five years and older more than quadrupled from 50,993 in 1975 to 241,641 in 2013.[27] Physicians sixty-five and older currently represent twenty-three percent of physicians in the United States."[28] One study estimates that of those 241,641 physicians sixty-five years and older, 20,000 are practicing surgeons seventy years and older.[29]

Many of the cognitive functions that decline with age are necessary to successfully perform surgery.[30] Specific occupational concerns for surgeons include working memory, processing speed, decision-making speed, falling asleep on the job, vision fatigue/declining visual acuity, and precision errors.[31] Understanding these occupational concerns is important for the medical community at large to assess its employment practices as well as for informing an individual surgeon's decision to retire.[32] A 2010 study from the University of Michigan looked at cognitive tests administered to practicing and retired surgeons that measured visual sustained attention, reaction time, visual learning and memory.[33] Data from the test results were disaggregated to compare between two categories: surgeons aged sixty years and older and surgeons between forty-five and fifty-nine years old.[34] The results showed that:

> 61 percent of practicing senior surgeons performed within the range of the younger surgeons on all cognitive tasks. 78 percent of practicing senior surgeons aged 60 to 64 performed within the range of the younger surgeons on all tasks compared with 38 percent of practicing senior surgeons aged 70 and older. 45 percent of retired senior surgeons performed within the range of the younger surgeons on all tasks. No senior surgeon performed below the younger surgeons on all three tasks.[35]

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content/uploads/2016/02/AMA-Council-on-Medical-Education-Aging-Physician-Report-2015.pdf.

27. *Id.*
28. *Id.*
29. Mark R. Katlic & JoAnn Coleman, *The Aging Surgeon*, 260 ANNALS SURGERY 199, 199 (2014).
30. Harada, *supra* note 19.
31. *Id.*
32. *See generally id.*
33. Lauren L. Drag et al., *Cognitive Functioning, Retirement Status, and Age: Results from the Cognitive Changes and Retirement among Senior Surgeons Study*, 211(3) J. AM. COLL. SURGEONS 303, 303–07 (2010).
34. *Id.* at 303.
35. *Id.*

In the context of employment practices, these results are important for two reasons.[36] For one, the results show that there is a statistically significant difference in the cognitive performance of surgeons above and below age sixty.[37] Second, these results imply that there is no one-size-fits-all solution.[38] Cognitive impairment affects people differently at all ages and may not affect others at all.[39]

2. TECHNOLOGICAL ADVANCES IN MEDICINE POSE AN AGE-SPECIFIC RISK

Technological advances in medicine are happening more and more rapidly.[40] As with the case of Dr. Doe, if a surgeon does not adopt new practices, he or she can harm patients and expose themselves and their employers to liability.[41] This is generally because elderly people sometimes find themselves struggling to adapt to new technologies.[42] Though many elderly people express eagerness to learn, numerous barriers hold them back from integrating new technologies into their lives.[43] These barriers include lack of instruction and guidance, lack of knowledge and confidence, health-related concerns, cost, feelings of being overwhelmed, feelings of inadequacy (especially compared to younger generations), and skepticism about using new technology.[44] Furthermore, fluid cognitive abilities begin to decline after one's third decade of life.[45] Fluid cognitive abilities include the ability to process and learn new information and manipulate one's environment.[46] Examples of fluid cognitive abilities include executive function, processing speed, memory, and psychomotor ability.[47] The decline of these fluid

36. *Id.* at 306–07.
37. *Id.* at 306.
38. *Id.* at 306–07.
39. *Id.*
40. Bertalan Meskó et al., *Digital Health is a Cultural Transformation of Traditional Healthcare*, 3 MHEALTH 1, 1–8 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5682364/.
41. *See generally* Blasier, *supra* note 1.
42. *See* Conger & Griffith, *supra* note 18.
43. Eleftheria Vaportzis et al., *Older Adults Perceptions of Technology and Barriers to Interacting with Tablet Computers: A Focus Group Study*, 8 FRONTIERS PSYCH. 1, 1 (2017).
44. *Id.*
45. Harada, *supra* note 19, at 739.
46. *Id.*
47. *Id.*

cognitive abilities makes it increasingly more difficult for elderly people to learn and use new technologies.[48]

Declining fluid cognition poses a particular risk for surgeons as health and medicine are becoming increasingly digital.[49] While robotics have been used in surgery for decades, artificial intelligence is considered by many scholars to be the new frontier.[50] For patients, the use of healthcare wearables—technology that the patient wears which sends health data straight to the patient's doctor—increased in the United States from nine percent in 2014 to thirty-three percent in 2018.[51] Some researchers go as far as to say that there is a cultural paradigm shift as "e-patients," those who are leveraging new health technologies to exercise more autonomy over their medical decisions, now view physicians as guides rather than as medical authorities.[52] While discussing the risks of non-expert patients making their own medical decisions, these researchers fault the reluctance of physicians to integrate new health technologies into their practice.[53] Yet, this conclusion is short-sighted and ageist. These researchers did not consider that some of the reluctance is due to the technological barriers faced by the elderly rather than stubborn resistance to change.[54] Regardless, the increasing digitalization of healthcare will inevitably mean some elderly surgeons, such as Dr. Doe, will fall by the wayside.[55]

Another growing issue facing elderly surgeons is the adoption of Electronic Health Records ("EHRs"). In 2009, then-President Obama passed the 2009 Health Information Technology Act ("HITECH Act") with the goal of using EHRs to improve efficiency and care coordination among providers.[56] The HITECH Act mandates that healthcare providers adopt and demonstrate "meaningful use" of EHRs to

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48. *See generally id.*
49. *See generally* Meskó, *supra* note 40.
50. Michael McFarlane, *Artificial Intelligence: The New Frontier in Surgery*, 2 EUR. J. MED. & HEALTH SCI. 1, 1 (2020); *No longer science fiction, AI and robotics are transforming healthcare*, PWC GLOB., https://www.pwc.com/gx/en/industries/healthcare/publications/ai-robotics-new-health/transforming-healthcare.html (last visited Oct. 21, 2021).
51. Alicia Phaneuf, *Latest trends in medical monitoring devices and wearable health technology*, BUS. INSIDER (Jan. 11, 2021, 11:48 AM), https://www.businessinsider.com/wearable-technology-healthcare-medical-devices.
52. Meskó, *supra* note 40, at 2–3.
53. *Id.* at 5.
54. *See generally id.*
55. *Id.* at 1.
56. *What is the HITECH Act?*, HIPAA J., https://www.hipaajournal.com/what-is-the-hitech-act/ (last visited Oct. 21, 2021).

maintain their existing Medicaid and Medicare reimbursement levels.[57] "Meaningful use" is vaguely defined; it is "the use of certified EHR technology in a meaningful manner (for example, electronic medication prescribing); ensuring that the certified EHR technology connects in a manner that provides for the electronic exchange of health information to improve the quality of care."[58] Providers who adopt and meaningfully use EHRs qualify for financial incentives.[59] Providers who are noncompliant face financial penalties such as a reduction in Medicare reimbursements.[60]

Elderly physicians, including surgeons, are frustrated with EHRs.[61] Many EHRs are run by third-party software programs that maximize device interoperability, but do so at the expense of user-friendliness.[62] This is extremely problematic in a situation where simply mis-clicking an option in a drop-down menu or checking the wrong box can lead to prescribing the wrong medication or inputting the wrong diagnosis on one's medical chart.[63] These errors, in turn, may expose a provider to medical malpractice liability.[64]

Grappling with this new technology increases frustration, burnout, and clerical burden for elderly physicians while also reducing clinical efficiency.[65] To combat this occupational stress, some physicians, including the American College of Surgeons ("ACS"), a professional association for surgeons, banded together to pressure the government to

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57. 42 U.S.C. § 201 note; *Federal Mandates for Healthcare: Digital Record-Keeping Requirements for Public and Private Healthcare Providers*, USF HEALTH ONLINE (Nov. 2, 2020), https://www.usfhealthonline.com/resources/healthcare/electronic-medical-records-mandate/.

58. *Public Health and Promoting Interoperability Programs: Introduction*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ehrmeaningfuluse/introduction.html (last updated Aug. 23, 2021).

59. *Federal Mandates for Healthcare*, *supra* note 57.

60. *Id.*

61. Carey Goldberg, *Mass. Doctors Join to Vent Frustrations with Electronic Health Records*, WBUR NEWS | COMMONHEALTH (Sept. 28, 2015), https://www.wbur.org/commonhealth/2015/09/28/doctors-vent-frustrations-emr; Keith Loria, *Physicians Leaving Profession Over EHRs*, MED. ECON. (Jan. 24, 2018), https://www.medicaleconomics.com/view/physicians-leaving-profession-over-ehrs.

62. Software, EPIC, https://www.epic.com/software (last visited Oct. 10, 2021).

63. Darrell Ranum, *Electronic Health Records Continue to Lead to Medical Malpractice Suits*, THE DRS. CO. (Aug. 2019), https://www.thedoctors.com/articles/electronic-health-records-continue-to-lead-to-medical-malpractice-suits/; Jodi Terranova, *Drop-down Menus: The Pitfalls of Electronic Medical Records, Part II*, PRO. LIAB. ADVOC. (June 5, 2014), https://www.professionalliabilityadvocate.com/2014/06/drop-down-menus-the-pitfalls-of-electronic-medical-records-part-ii/.

64. *Id.*

65. Loria, *supra* note 61.

relax its mandate on EHRs.[66] Yet, the stress of integrating EHRs has also led other physicians to stop practicing completely.[67] If EHRs are here to stay, then, so too are the age-specific risks of technological advances in medicine.[68]

B. A Lack of Sufficient Safeguards

Unlike other professions such as airline pilots, the medical profession does not have sufficient safeguards against the increased risk of medical malpractice by elderly surgeons.[69] For one, it is very difficult for a surgeon to be forced to stop practicing.[70] Secondly, the present system of internal reporting mechanisms is not adequately used.[71] Lastly, these internal reporting mechanisms largely rely on self-policing, but surgeons generally resist retirement and are not reliable judges of their own competency.[72] The following subsections detail these three factors.

1. IT IS VERY DIFFICULT TO BE FORCED TO STOP PRACTICING

A physician must obtain an unrestricted medical license in every state he or she wishes to practice medicine.[73] But obtaining one's license is the hard part—keeping it is easy.[74] In fact, there are only two ways to lose one's medical license: letting your license lapse or having your license revoked by the state medical board.[75] Despite the large number of medical malpractice claims, license revocations are few and far

66. Goldberg, *supra* note 61; Vinita Ollapaly, *EHRs add to surgeons' administrative burdens: The ACS responds*, BULL. AM. COLL. SURGEONS (Sept. 1, 2018), https://bulletin.facs.org/2018/09/ehrs-add-to-surgeons-administrative-burdens-the-acs-responds/.

67. Loria, *supra* note 61.

68. *Id.*

69. *See* John Fauber & Matt Wynn, *7 takeaways from our year-long investigation into the country's broken medical license system*, USA TODAY, https://www.usatoday.com/story/news/2018/11/30/medical-board-license-discipline-failures-7-takeaways-investigation/2092321002/ (last updated Nov. 30, 2018, 9:30 AM).

70. *See id.*; *see also* Naveed Saleh, *Top disciplinary actions taken by medical boards*, MDLINX (Jan. 15, 2019), https://www.mdlinx.com/article/top-disciplinary-actions-taken-by-medical-boards/lfc-3293.

71. *See* Paula Span, *When Is the Surgeon Too Old to Operate?*, N.Y. TIMES (Feb. 1, 2019), https://www.nytimes.com/2019/02/01/health/surgeons-retirement-competence.html.

72. *See* Katlic & Coleman, *supra* note 29, at 200; Blasier, *supra* note 1, at 405–06.

73. *Obtaining a Medical License*, AM. MED. ASS'N (May 15, 2018), https://www.ama-assn.org/residents-students/career-planning-resource/obtaining-medical-license.

74. *See generally* Fauber & Wynn, *supra* note 69.

75. *Id.*

between.[76] In 2017, the medical boards of all fifty states, U.S. territories, and the District of Columbia only pursued a combined total of 264 cases of disciplinary action for license revocation[77] Of those cases, the vast majority of reasons for license revocation are not general incompetence or malpractice, but rather, overtly criminal behavior such as years of sexually abusing patients.[78] For example, of seventy-three doctors received warning letters from the FDA for peddling fake cancer cures over a five year period, only one was subjected to disciplinary action.[79] Many physicians caught having sexual relations with patients are not disciplined, but rather, subject to agreements that he or she must practice with a chaperone.[80] Thus, it is quite likely that Dr. Doe, whose surgeries were "abnormally bloody" and led to one patient's death, faced no disciplinary action from his state's medical board.[81] In addition, if one's license ultimately does get revoked in one state, the physician can simply get licensed and continue practicing in another state (while there are databanks, such as the National Practitioner Data Bank, that collect adverse information about physicians, querying such databanks is not mandatory for state medical boards.).[82] Clearly, the current legal mechanisms are not sufficient to safeguard against incompetent surgeons.[83]

2. INTERNAL REPORTING MECHANISMS ARE ONLY EFFECTIVE IF USED

There is no national standard for screening surgeon competency after a certain age.[84] In theory, the only internal safeguards against competency issues are a surgeon's professional obligation to patient safety and an employer's decision to fire an incompetent surgeon.[85] But this self-policing strategy is not effective.[86] Recently, one surgeon, who was

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76. *See* Saleh, *supra* note 70.
77. *Id.*
78. Fauber & Wynn, *supra* note 69.
79. *Id.*
80. *Id.*
81. *See generally id.*
82. Fauber & Wynn, *supra* note 69; NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/topNavigation/timeline.jsp, (last visited Oct. 23, 2021); *Who Can Query and Report to the NPDB?*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/resources/tables/whoCanQueryReport.jsp (last visited Oct. 23, 2021).
83. *See generally* Fauber & Wynn, *supra* note 69.
84. *Competency and retirement*, *supra* note 20.
85. *Id.*; Katlic & Coleman, *supra* note 29, at 200.
86. *See* Span, *supra* note 71.

performing operations into his eighties, opined, "[t]he public believes we police ourselves as a profession. We don't, at least not very well."[87] In practice, employers often do not become aware of issues with physicians until death occurs or a malpractice suit arises.[88]

One reason for the lack of reporting is that younger physicians do not feel comfortable reporting senior physicians.[89] As exemplified by the case of Dr. Doe, a major barrier to younger medical staff reporting concerns about senior physicians is a sense of guilt.[90] Younger physicians feel that they should be learning from and looking up to elderly physicians, and are also worried about jeopardizing someone else's career.[91] In an article by Jennifer Adaeze Okwerekwu, she discusses her struggle as a resident with "snitch guilt" after reporting an elderly doctor who exhibited signs of cognitive decline, even after his repeated medical errors began threatening patient safety.[92] Unfortunately, this guilt is pervasive in the medical community.[93] As Okwerekwu laments, "the people 'in the best position to see how dangerous' these doctors have become, are often in 'the worst position to do anything about it.'"[94]

3. PHYSICIANS RESIST RETIREMENT

People do not like to be told when to retire.[95] Fortunately for surgeons, the decision to retire is entirely their own.[96] Yet, surgeons generally resist retirement.[97] Why? One reason why surgeons resist

87. *Id.*

88. *See* AMA 2015 Report, *supra* note 26 ("Although individual peers reporting on each other is the prime mechanism for identifying physicians whose knowledge, skills, or attitudes are compromised, and most physicians agree that impaired or incompetent physicians should be reported to the appropriate authorities, this method is not always reliable. A study by Campbell et al. showed that 45 percent of those with direct personal knowledge of a physician in their hospital group or practice who was impaired or incompetent did not always report that physician. Contemporary methods of self-regulation … have been created by the profession in part due to increasing recognition that sole reliance on individual physicians to report colleagues' performance, even if it were 100 percent reliable, still would not be enough to meet shared obligations for quality assurance and patient safety.").

89. Blasier, *supra* note 1; AMA 2015 Report, *supra* note 26.

90. *See generally* AMA 2015 Report, *supra* note 26.

91. Blasier, *supra* note 1; Okwerekwu, *supra* note 6.

92. Okwerekwu, *supra* note 6.

93. *See id.*

94. *Id.* (quoting Dr. Atul Gawande).

95. *See* Hanna van Solinge & Kène Henkens, *Involuntary Retirement: The Role of Restrictive Circumstances, Timing, and Social Embeddedness*, 62 J. GERONTOLOGY S295, S295 (2007).

96. Blasier, *supra* note 1.

97. *Id.*

retirement is because they often do not perceive their own declining competency.[98] A survey of 995 surgeons showed that most senior surgeons reported no changes in their perceived cognitive abilities as they aged.[99] Thus, since surgeons perceive themselves as still being able to give the highest quality of care, they do not perceive a threat to their ethical obligation to patient safety.[100]

One doctor, Richard L. Rovit, posited three additional—albeit esoteric—reasons why surgeons in particular resist retiring: (1) lack of self-esteem; (2) fear of death; and (3) resistance to change.[101] Rovit suggests that a surgeon's self-esteem is inseparable from his or her work as a surgeon and thus, if the surgeon were to stop performing surgeries, he would no longer value himself as a person.[102] He also suggests that surgeons fear death and disease.[103] There is a saying among surgeons that "surgery is for patients, not for surgeons."[104] In other words, removing a surgeon's ability to conduct surgery removes the psychological barrier between surgeon and patient, thereby rendering the surgeon vulnerable to the diseases he or she treats.[105] Lastly, Rovit suggests resistance to change as an impediment to retirement, a feeling not exclusive to surgeons or physicians since retirement is a major life milestone for all working people, which signifies the end of a significant chapter in their life.[106]

Lack of sufficient legal mechanisms and internal reporting safeguards are failing to mitigate the risks posed by aging surgeons.[107] Without strengthening these mechanisms, liability will continue to be a concern for physicians, employers, and patients alike.[108]

98. Katlic & Coleman, *supra* note 29; *see* H. Jin Lee et al., *Results from the Cognitive Changes and Retirement Among Senior Surgeons Self-Report Survey*, 209 J. AM. COLL. SURGEONS 668, 668 (Sept. 19, 2009), https://pubmed.ncbi.nlm.nih.gov/19854410/#:~:text=Background%3A%20The%20Cognitive%20Changes%20and,not%20predict%20objective%20cognitive%20performance.

99. Katlic & Coleman, *supra* note 29.

100. *See id.*

101. Blasier, *supra* note 1, at 406.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *See* AMA 2015 Report, *supra* note 26.

108. *Id.*

C. The Medical Community's Response to the Issue

The problem of the aging surgeon is not a secret in the medical community (though it may be taboo).[109] In recent years, various medical associations began investigating the issue and making policy recommendations.[110] In addition, private healthcare entities are starting to implement their own internal policies and programs to screen and assess aging surgeons before problems arise.[111] This subsection details the AMA's stance on the aging physician as well as specific private programs that are being piloted at Sinai Hospital in Baltimore, Maryland and Yale New Haven Hospital.[112]

1. THE AMA'S STANCE ON COMPETENCY AND THE AGING PHYSICIAN

The AMA is the largest association of physicians and medical students in the United States.[113] The AMA's mission is to "promote the art and science of medicine for the betterment of the public health, to advance the interests of physicians and their patients, to promote public health, to lobby for legislation favorable to physicians and patients, and to raise money for medical education."[114] The AMA has seven councils that report and make suggestions to the Board of Trustees or House of Delegates on various issues related to physicians and patients.[115] Councils are comprised of physicians, medical students, residents, and fellows.[116]

One such council is the AMA's Council on Medical Education ("Council"), which is tasked with recommending educational and continuing professional development policies to the AMA's House of Delegates.[117] In 2015, the Council convened to discuss the issue of the aging

109. *Id.*

110. *Id.*; THE COUNCIL ON MED. EDU., *Competency of Senior Physicians*, AM. MED. ASS'N I-18 (2018) [hereinafter AMA 2018 Report].

111. *See, e.g.*, *The Aging Surgeon Program*, LIFEBRIDGE HEALTH, http://agingsurgeonprogram.com/AgingSurgeon/AgingSurgeon.aspx (last visited Oct. 23, 2021).

112. Abigail Frazer & Michael Tanzer, *Hanging Up the Surgical Cap: Assessing the Competence of Aging Surgeons*, 12 WORLD J. ORTHOPEDICS 234, 238 (2021).

113. American Medical Association (AMA), LIBR. OF CONG., https://www.loc.gov/item/lcwaN0007188/ (last visited Oct. 23, 2021).

114. *Id.*

115. *Councils*, AM. MED. ASS'N, https://www.ama-assn.org/councils (last visited Oct. 23, 2021).

116. *Id.*

117. *About the Council on Medical Education*, AM. MED. ASS'N, https://www.ama-assn.org/councils/council-medical-education/about-council-medical-education (last visited Oct. 23, 2021).

physician.[118] The Council resolved to establish a workgroup of stakeholders to research and develop guidelines for screening and assessing elderly physicians for cognitive impairment.[119] In December 2017, the workgroup had a conference call to discuss results of recent surveys regarding screening, assessment, and educational practices of members of various organizations such as the Federation of State Medical Boards.[120] Survey results showed that most respondents were not screening or assessing senior physicians and only 9.2% offered educational resources regarding the effects of age on physician practice.[121]

Despite these findings, the ultimate resolution of the Council was an official stance against mandatory retirement ages or the imposition of guidelines by others, as well as a commitment to strictly adhere to formal AMA guidelines for monitoring and assessing aging physician competency.[122] One concern the Council raised about nationally implemented mandatory retirement ages or guidelines by others—presumably, governmental bodies—is that these rules or guidelines would not be evidence-based.[123] Another reason for this stance is that, according to the AMA, "[i]t is in physicians' best interest to proactively address issues related to aging in order to maintain professional self-regulation. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation."[124]

The AMA is large and influential.[125] Thus, while it is aware of the problem of the aging surgeon, it will likely push back legally or politically on any policy or program to address aging surgeons that is inconsistent with its stance.[126]

118. AMA 2015 Report, *supra* note 26.
119. *Id.*
120. AMA 2018 Report, *supra* note 109.
121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.*
125. Brittany La Couture, *The Traveling Doctor: Medical Licensure Across State Lines*, AM. ACTION FORUM (June 10, 2015), https://www.americanactionforum.org/insight/the-traveling-doctor-medical-licensure-across-state-lines/.
126. *See generally id.* ("Although the AMA does serve to raise quality of care and protect consumers from charlatans, its primary goal is to advance the interests of its members—including their financial interests.").

2. WHAT IS CURRENTLY BEING DONE TO ADDRESS THE ISSUE

Consistent with the desire to self-regulate, medical associations and healthcare providers began making recommendations and implementing pilot programs to screen and assess senior physician competency.[127] In 2016, the ACS recommended surgeons undergo voluntary physical examinations and voluntarily take online neurocognitive assessments starting between ages sixty-five and seventy.[128] The ACS reiterated that taking these measures would be incumbent on the surgeon, in accordance with their professional duty to patient safety, to report any concerning findings.[129] In other words, reporting is still completely voluntary.

One pilot program to screen and assess senior physician competency is "The Aging Surgeon Program" launched in 2014 by Sinai Hospital of Baltimore, Maryland.[130] It is a program by surgeons, for surgeons, and was an idea advocated by the ACS about twenty-five years ago.[131] The Aging Surgeon Program is a "comprehensive, multidisciplinary, objective and unbiased evaluation of physical and cognitive function for older surgeons."[132] Results of a surgeon's evaluation would be used by surgeons and employers to make informed decisions about a surgeon's continuing ability to practice.[133] To date, the Aging Surgeon Program is in its fledgling stages. As of 2019, the program has only screened eight surgeons.[134] This low participation rate is also due to the program being voluntary.[135]

Another pilot program example is Yale New Haven Hospital's "Late Career Practitioner Policy" ("the Policy"), which was launched in 2016.[136] The Policy was created by the self-governing Medical Staff Executive Committee and the Peer Review Credentialing Committee and was adopted by the Hospital.[137] It requires all physicians and other practitioners over the age of seventy to undergo a neuropsychological screening and ophthalmologic (eyesight) exam at the time of their initial

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127. AMA 2018 Report, *supra* note 109.
128. *Id.*
129. *Id.*
130. *The Aging Surgeon Program*, *supra* note 111.
131. Katlic & Coleman, *supra* note 29.
132. *The Aging Surgeon Program*, *supra* note 111.
133. *Id.*
134. Span, *supra* note 71.
135. *See id.*
136. Defendants's Answer To Plaintiff's Complaint at 4–5, EEOC v. Yale New Haven Hosp., No. 3:20-cv-00187 (D. Conn. filed May 12, 2020) ¶¶ 18–19, 22.
137. *Id.*

appointment or reappointment in order to obtain or renew their practicing privileges.[138] Recent figures show that of the 145 individuals tested under the Policy, fourteen were found to be "Borderline deficient," one was "Deficient," and seven "Failed."[139] In February 2020, the U.S. Equal Employment Opportunity Commission ("EEOC") filed a lawsuit against Yale Hospital ("the Yale case") alleging the Policy violated the ADEA and the ADA.[140] The Yale case is the first of its kind to challenge individual testing policies for older physicians.[141] The outcome of the Yale case will have huge implications for these kinds of programs.[142]

III. Analysis

Cognitive and physical decline is an inevitable part of aging.[143] As the proportion of surgeons aged sixty-five and older increases, so do concerns about the risks associated with cognitive and physical impairment.[144] In particular, the tide of digital healthcare poses an age-specific risk.[145] There are little to no safeguards for patients against elderly surgeons who develop cognitive and physical impairments or who do not adapt to new technology.[146] And while the medical community is generally aware of the need for cognitive and physical testing for aging surgeons, the field is concerned about non-physicians imposing rules and guidelines that are not evidence-based.[147] Therefore, some organizations and healthcare providers, such as Yale Hospital, are beginning to make recommendations and implement pilot programs for screening and assessment.[148] Yet, these employment practices raise questions under anti-discrimination laws.[149] Furthermore, unless every healthcare provider in the United States agrees to implement a screening and assessment program *and also* agrees to adhere to and enforce remedies for

138. *Id.*
139. Plaintiff's Complaint, EEOC v. Yale New Haven Hosp. at 6, No. 3:20-cv-00187 (D. Conn. filed Feb. 11, 2020) ¶ 22.
140. *Id.* at 6–8 ¶¶ 23–31.
141. *See generally id.* at 1–10.
142. *See generally id.*
143. Harada, *supra* note 19.
144. Harada, *supra* note 19; *Arthritis Related Statistics*, *supra* note 23.
145. Conger & Griffith, *supra* note 18; Ranum, *supra* note 63.
146. *See infra* Section II.B.
147. AMA 2015 Report, *supra* note 26; AMA 2018 Report, *supra* note 109.
148. *See infra* Section II.C.2.
149. *See infra* Section III.A.

surgeons found to be cognitively or physically impaired, negative clinical outcomes and malpractice will continue to occur.[150] In response, some lawmakers are calling for legislation mandating retirement ages for surgeons.[151] Lawmakers considering this idea may look to retirement schemes in other professions as guides for future action.

A. Individual Medical Testing Under the ADEA and ADA

One potential solution to the aging surgeon problem is mandatory medical testing for surgeons who reach a certain age.[152] As exemplified by the Yale Policy, a few health systems already offer this option for all types of physicians, either on a voluntary basis or mandated as part of a system-wide policy.[153] Practicing attorneys differ on the legality of these policies; some defend them,[154] while others believe they are illegal under the ADEA and ADA.[155] A third category of practicing attorneys believe that blanket policies for physicians over a certain age may not hold up in court, but policies tailored to specific practice areas, such as surgery, may be viable.[156] Though courts have weighed in on the issue of medical testing for other occupations, they have yet to weigh in on medical testing for physicians.[157] Fortunately, guidance on the issue may come soon with the outcome of the Yale case. Yet, its precedential value may not extend beyond the District of Connecticut, as it would not necessarily be binding on similar policies in other jurisdictions.[158] Thus, a more robust legal framework for analyzing these policies is needed and likely to become pertinent in the future as more health

150. *See generally* AMA 2015 Report, *supra* note 26; AMA 2018 Report, *supra* note 110.

151. AMA 2015 Report, *supra* note 26; AMA 2018 Report, *supra* note 110.

152. Span, *supra* note 71.

153. *Id.*

154. Defendant's Answer To Plaintiff's Complaint, EEOC v. Yale New Haven Hosp., No. 3:20-cv-00187 (D. Conn. filed May 12, 2020).

155. Grandjean & Grell, *supra* note 11.

156. Mary M. McCudden, *Navigating the Waters of Late Age Physician Testing*, 8 NAT'L L. REV. 67 (2018), https://www.natlawreview.com/article/navigating-waters-late-age-physician-testing.

157. *See, e.g.*, Epter v. N.Y. City Transit Auth., 216 F. Supp. 2d 131 (E.D.N.Y. 2002); EEOC v. Commonwealth of Mass., 987 F.2d 64 (1st Cir. 1993).

158. Barbara Bintliff, Mandatory v. Persuasive Cases, 9 PERSPS.: TEACHING LEGAL RSCH. & WRITING (2001), https://info.legalsolutions.thomsonreuters.com/pdf/perspec/2001-winter/winter-2001-7.pdf.

systems around the United States consider implementing similar policies and programs.[159]

B. The ADEA

One concern about policies or programs to test the competency of aging surgeons is that such programs would violate the ADEA.[160] In 1967, Congress enacted the ADEA to protect employees and job applicants age forty and older from employment discrimination.[161] The ADEA prohibits discrimination against a person because of his or her age with respect to any term, condition, or privilege of employment, including hiring, firing, promotion, layoff, compensation, benefits, job assignments, and training.[162] The provisions of the ADEA apply to most employers in the public and private sector who have over twenty employees.[163] A plaintiff can establish a prima facie case that an employer's act or policy is discriminatory, but the ADEA makes an exception if the employer can establish that the age limitation is a bona fide occupational qualification ("BFOQ").[164] This exception is frequently used in litigation to defend hiring age caps and mandatory retirement ages.[165] The outcome of these cases indicate a preference for "deal[ing] with older employees on an individualized basis."[166] Yet, the majority of these cases were litigated in the twentieth century when advocates did not have the medical capability to test older employees on an individual basis.[167]

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159. *See generally* Span, *supra* note 71; McCudden, *supra* note 156.
160. McCudden, *supra* note 156.
161. *Facts About Age Discrimination*, EEOC (Sept. 8, 2008), https://www.eeoc.gov/fact-sheet/facts-about-age-discrimination.
162. *Id.*
163. *Age Discrimination*, EEOC, https://www.eeoc.gov/age-discrimination# (last visited Oct. 23, 2021); *Coverage,* EEOC, https://www.eeoc.gov/employers/coverage-0 (last visited Oct. 23, 2021).
164. Elizabeth Lang-Miers, *Age – Situations where employers can properly consider age–Establishing the BFOQ defense*, TEX. EMPL. PRAC. DEC. § 3:7 (2020) (BFOQs are affirmative defenses used by employers once a plaintiff has made out a prima facie case for age-discrimination).
165. *See generally* LEGAL INFO. INST., *bona fide occupational qualification* (BFOQ), CORNELL L. SCH. [hereinafter BFOQ], https://www.law.cornell.edu/wex/bona_fide_occupational_qualification_(bfoq) (last visited Oct. 23, 2021).
166. Western Air Lines, Inc. v. Criswell, 472 U.S. 400, 400 (1985).
167. *See, e.g.*, EEOC v. Commonwealth of Mass., 987 F.2d 64 (1st Cir. 1993); Western Air Lines Inc., 472 U.S. at 400; Ido Badash et al., *Innovations in Surgery Simulation: A Review of Past, Current and Future Techniques*, 4 ANNALS TRANSLATIONAL MED. 453–463 (2016).

It seems as though that time has come. As more healthcare systems adopt mandatory testing policies for elderly physicians, the number of lawsuits challenging those policies under the ADEA, such as the Yale case, will surely rise.[168] Attorneys defending those policies will likely be tempted to invoke a BFOQ defense as they have in the Yale case.[169] As will be discussed in the following section, however, this defense presents unique challenges for attorneys and may be a legal dead-end for both plaintiffs and defendants.

C. What is a BFOQ?

A BFOQ exists if: "(1) the alleged BFOQ is reasonably necessary to the essence of the particular business; and (2) there is a factual basis to believe that most class members cannot perform the job safely and efficiently, or the excluded class members cannot be evaluated on an individual basis."[170] BFOQs are construed narrowly and are typically disfavored by courts.[171] Yet it is important to note that many courts have held that the burden of proof to establish a BFOQ is minimized in "the presence of an overriding safety factor, *i.e.* where safety is "the essence" of a particular business such as the transportation by bus or airplane."[172] Furthermore, courts regularly uphold employment practices in government where a particular statute allows for policies and practices otherwise prohibited by the ADEA.[173] Courts will also frequently uphold certain policies and practices in the private sector when the employer can prove that the policy or practice is analogous to the statutorily permissible government practice.[174] Instances of courts upholding BFOQs include gender-based hiring in female prison housing units,[175] religion-

168. EEOC v. Yale New Haven Hosp., No. 3:20-cv-00187 (D. Conn. filed May 12, 2020).

169. *See, e.g.*, Defendant's Answer. To Plaintiff's Complaint, EEOC v. Yale New Haven Hosp., (No. 3:20-cv-00187) (D. Conn. filed May 12, 2020).

170. Lang-Miers, *supra* note 164.

171. THOMSON REUTERS, *Bona Fide Occupational Qualification (BFOQ)*, Prac. L. Glossary 5-501-6343, https://ca.practicallaw.thomsonreuters.com/5-501-6343?transitionType=Default&contextData=(sc.Default)&firstPage=true (last visited Oct. 23, 2021).

172. Maki v. Comm'r of Educ. of N.Y., 568 F. Supp. 252, 254–55 (N.D.N.Y. 1983).

173. Eric Handelman, *Proof of Age as Bona Fide Occupational Qualification Under ADEA*, 135 AM. JUR. PROOF OF FACTS 3d § 5 (2020).

174. *Id.*

175. Everson v. Mich. Dep't of Corrs., 391 F.3d 737 (6th Cir. 2004).

based hiring at a Jesuit university,[176] and a mandatory retirement age for school bus drivers.[177]

1. APPLYING THE BFOQ TEST TO MEDICAL TESTING FOR ELDERLY SURGEONS

In the case of policies or practices targeting elderly surgeons, the first prong of the BFOQ test would almost certainly be satisfied because patient safety is necessary to the essence of surgery. Instances where age-based policies have passed the first prong of the BFOQ test include mandatory retirement ages for bus drivers, where the essence of the business is safely transporting passengers.[178] Passengers put their lives in the hands of bus drivers; should the bus driver not be able to operate the bus safely, passengers are at risk of injury and death.[179] For healthcare professionals, patient safety is a top—if not *the* top—priority.[180] This is especially true for the surgical profession and has even led the World Health Organization to launch a global campaign called "Safe Surgery Saves Lives."[181] In that light, it is difficult to see how a court could hold that safety is not the essence of the business of surgery;[182] similar to bus drivers, patients quite literally put their lives in the hands of surgeons, risking injury and death.

Conversely, the other half of the BFOQ test presents an interesting conundrum. The second prong contains an either-or option to be satisfied: either there is factual evidence that most class members cannot perform the job safely and efficiently or the excluded class members cannot be evaluated on an individual basis.[183] The first option would

176. Pime v. Loyola Univ. Chi., 803 F.2d 351 (7th Cir. 1986).

177. Maki v. Comm'r of Educ. of State of N.Y., 568 F. Supp. 252 (N.D.N.Y. 1983), aff'd, 742 F.2d 1437 (2d Cir. 1984).

178. *Id.*

179. *Id.*

180. *Priorities in Focus–Patient Safety*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Mar. 2016), https://www.ahrq.gov/workingforquality/reports/priorities-in-focus/patient-safety.html.

181. WORLD ALLIANCE FOR PATIENT SAFETY, *Safe Surgery Saves Lives*, WORLD HEALTH ORG. 9 (2009), https://apps.who.int/iris/bitstream/handle/10665/70080/WHO_IER_PSP_2008.07_eng.pdf;jsessionid=9A0F696D5CF45029554BBE35130A5B92?sequence=1.

182. *See generally* Michelle Mello et al., *"Health courts" and accountability for patient safety*, NAT'L LIBRARY OF MED., https://pubmed.ncbi.nlm.nih.gov/16953807/ (discussing current proposals for the design of a health court system and the system's advantages for improving safety).

183. Lang-Miers, *supra* note 163.

most likely not be satisfied as it pertains to surgeons.[184] Though a critical mass of elderly surgeons may not be able to perform their job duties safely, there is no factual basis to believe that most elderly surgeons cannot do so.[185] Thus, we move to the second option: whether the excluded class members can be evaluated on an individual basis.[186] Here, the class members would be surgeons over a certain age.

Whether the class members can or cannot be evaluated on an individual basis presents an awkward situation for both plaintiff and defense attorneys as testing class members on an individual basis is the exact policy at issue (historically, this defense has been raised in the context of mandatory retirement ages or individual terminations).[187] To prove that a policy which mandates class members be tested individually *does* violate the ADEA, plaintiffs must prove that class members *can* be tested on an individual basis.[188] Conversely, to prove that a policy which mandates class members be tested individually *does not* violate the ADEA, defendants must argue that class members *cannot* be tested on an individual basis.[189] In light of this conundrum, the ADEA may not be a viable path to challenge policies or programs that individually assess and test elderly surgeons.[190] Instead, it may be more wise (though counterintuitive) for plaintiffs to challenge individual testing policies solely on the basis of violating the ADA.[191]

2. THE ADA

The ADA is a federal civil rights law that prohibits discrimination against individuals with disabilities.[192] The law was first enacted in

184. *See generally* Martin A. Makary et al., *Patient Safety in Surgery*, ANNALS OF SURGERY, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1570547/ (for a discussion on a comparison study on surgeons and safety).
185. Blasier, *supra* note 1; Span, *supra* note 71.
186. Lang-Miers, *supra* note 164.
187. *See generally* Lang-Miers, *supra* note 164; BFOQ, *supra* note 165.
188. *See generally Employment Tests and Selection Procedures*, U.S. EEOC, https://www.eeoc.gov/laws/guidance/employment-tests-and-selection-procedures (last visited Oct. 23, 2021) (providing information on employer use of employment tests and selection procedures, and the circumstances under which issues arise).
189. *Id*.
190. *See generally S. 1511–Older Workers Benefit Protection Act*, Congress.gov, https://www.congress.gov/bill/101st-congress/senate-bill/1511 (last visited Oct. 23, 2021) (summarizing the Older Workers Benefit Protection Act that amends the ADEA).
191. *What is the Americans with Disabilities Act (ADA)?*, ADA NAT'L NETWORK, https://adata.org/learn-about-ada (last visited Oct. 23, 2021).
192. *Id.*

1990.[193] In 2008, the ADA was amended in light of U.S. Supreme Court decisions and EEOC guidelines that narrowly construed the definition of "disability" and, consequently, denied protections to the many of the individuals the law had originally intended to protect.[194] Under the new amendment, the term "disability" should be construed broadly.[195] An individual has a disability under the ADA if he or she has "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment."[196] The text of the ADA does not list conditions that qualify as a disability.[197] Old age in and of itself is not considered a disability under the ADA, but many conditions that affect elderly people, such as dementia and arthritis, qualify as a disability.[198] Title I of the ADA governs employment practices regarding individuals with disabilities and is regulated and enforced by the EEOC.[199] Section (d) of Title I of the ADA prohibits employment discrimination through the use of medical examinations and disability-related inquiries "*unless such examination or inquiry is shown to be job-related and consistent with business necessity*."[200] Thus, any employment policy subjecting elderly surgeons to physical or cognitive testing must comply with Section (d).[201]

a. What is a "Medical Examination" Under the ADA?

The text of the ADA does not define "medical examination."[202] Consequently, what qualifies as a medical examination is often subject

193. *Id.*
194. *Understanding the Americans With Disabilities Act Amendments Act and Section 504*, NAT'L CTR. FOR LEARNING DISABILITIES (Sept. 23, 2019), https://ncld.org/get-involved/learn-the-law/understanding-the-americans-with-disabilities-act-amendments-act-and-section-504/.
195. *Notice Concerning The Americans With Disabilities Act (ADA) Amendments Act of 2008*, EEOC, https://www.eeoc.gov/statutes/notice-concerning-americans-disabilities-act-ada-amendments-act-2008 (last visited Oct. 23, 2021).
196. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et. seq. (2008), https://www.ada.gov/pubs/adastatute08.htm.
197. *Id.*
198. Aging and the ADA, ADA NAT'L NETWORK, https://adata.org/factsheet/aging-and-ada# (last visited Oct. 23, 2021).
199. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et. seq. (2008), https://www.ada.gov/pubs/adastatute08.htm.
200. *Id.* (*emphasis added*)
201. *See generally id.*
202. *Id.*

to litigation.[203] To clarify what is meant by "medical examination," in 2000, the EEOC issued enforcement guidance to help employers stay compliant with the ADA.[204] According to the EEOC, a "medical examination" under the ADA "is a procedure or test that seeks information about an individual's physical or mental impairments or health."[205] Since this definition is still relatively vague, the EEOC went on to enumerate seven factors that should be considered in determining whether a test or procedure is considered a medical examination, such as whether the test is administered and interpreted by a healthcare professional.[206] What is and is not a medical examination is often an exercise in splitting hairs.[207] For example, vision tests administered and interpreted by an optometrist are prohibited, whereas "tests that evaluate an employee's ability to read labels or distinguish objects as part of a demonstration of the ability to perform actual job functions" are not.[208]

b. When is a Surgeon an Employee?

This question seems facetious, but it is not. Not all surgeons are "employees" as traditionally defined by law.[209] Instead, many surgeons who have medical privileges at hospitals are considered independent contractors.[210] There are many factors that determine whether a

203. *See* EEOC, EEOC-CVG-2000-4, ENFORCEMENT GUIDANCE ON DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS OF EMPLOYEES UNDER THE ADA (2000) [hereinafter EEOC Enforcement Guide], https://www.eeoc.gov/laws/guidance/enforcement-guidance-disability-related-inquiries-and-medical-examinations-employees.

204. *Id.*

205. *Id.*

206. *Id.*

207. *See generally id.* ("In many cases, a combination of factors will be relevant in determining whether a test or procedure is a medical examination. In other cases, one factor may be enough to determine that a test or procedure is medical.").

208. *Id.*

209. 42 U.S.C. § 12111(4) (2008) ("The term 'employee' means an individual employed by an employer.").

210. Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees Under Title VII or the ADA Act when Alleging an Employment Discrimination Claim?*, 1 DEPAUL J. HEALTH CARE L. 119, 121 (1996); Will Kenton, Independent Contractor, INVESTOPEDIA (Oct. 15, 2021), https://www.investopedia.com/terms/i/independent-contractor.asp ("An independent contractor is a . . . person or entity contracted to perform work for–or provide services to–another entity as a nonemployee. As a result, independent contractors must pay their own Social Security and Medicare taxes. In addition, an . . . entity is not required to provide [the contractor] with employment benefits, such as health insurance, . . . that [they might] otherwise [be required to] provide [were the contractor an employee]. . . . Another term for an independent contractor is a 'freelancer.'").

physician is an employee or an independent contractor, such as whether the physician is dependent on medical equipment provided by the employer.[211] This distinction becomes especially contentious in employment litigation because independent contractors are not covered by employment and labor laws such as Title VII (a.k.a. the Civil Rights Act of 1964), the ADEA, or the ADA.[212] Yet, the distinction between employees and independent contractors is blurry and courts are historically split on the issue.[213] While there is a general trend toward holding hospital-employers liable under these federal statutes even if the employee is found to be an independent contractor, the split remains.[214] As recently as August 2020, the Ninth Circuit held that one surgeon in Hawaii was an independent contractor and thus, was not protected by Title VII.[215] The Supreme Court has yet to weigh in on this issue, but it is important to note that these cases are evaluated on an individual basis since employment contracts differ and—particularly in the medical field—are constantly changing.[216] This distinction is incredibly significant for employers who wish to require medical tests for surgeons over a certain age, and employers will likely defend claims of discrimination on the grounds that the surgeon is an independent contractor and not an employee.[217] In the Yale case, the parties avoided litigating this issue by stipulating which staff members are employees and which are not.[218]

c. When Can Medical Examinations be Given by Employers?

Similar to the employee status consideration, the medical examination provision of the ADA also applies differently depending on the individual's status in the employment process.[219] Specifically, the ADA distinguishes three stages of employment: (1) pre-offer, (2) post-offer,

211. Lowe, *supra* note 210, at 129.
212. Admin. for Child. & Fam., *What's the Difference Between an Independent Contractor and an Employee?*, U.S. DEP'T OF HEALTH & HUM. SERVS. (June 15, 2020), https://www.acf.hhs.gov/css/resource/the-difference-between-an-independent-contractor-and-an-employee.
213. Lowe, *supra* note 210, at 121.
214. *Id.*
215. Henry v. Adventist Health Castle Med. Ctr., 970 F.3d 1126, 1133 (9th Cir. 2020).
216. Lowe, *supra* note 210, at 121.
217. *See* Shah v. Deaconess Hosp., 355 F.3d 496 (6th Cir. 2004).
218. Ord. Granting the Parties' Joint Mot. to Approve Stipulation Regarding Employer Status of Yale New Haven Hospital, Inc., EEOC v. Yale New Haven Hospital, No. 3:20-cv-00187 (D. Conn. Jan. 22, 2021), ECF No. 61.
219. EEOC Enforcement Guide, *supra* note 203.

but pre-employment, and (3) active employment.[220] In the pre-offer stage, medical examinations are prohibited in all circumstances, even if job-related.[221] In the post-offer/pre-employment stage, medical examinations are permitted regardless of whether they are job-related or not, as long as the employer requires the examination for every single individual in the post-offer stage.[222] In other words, in the post-offer stage, an employer cannot require surgeons over a certain age to submit to a medical examination but not require the same for surgeons below that age.[223] Lastly, in the active employment stage, an employer may only require medical examinations if the examinations are job-related and consistent with business necessity.[224]

As such, even if a particular test an employer uses is deemed a medical examination under the ADA, it is not automatically prohibited.[225] Once employment begins, an employer may still be permitted to require the test if they can prove the test is job-related and consistent with business necessity.[226] The ADA does not define "job-related and consistent with business necessity," but the EEOC Enforcement Guide and relevant case law shed light on the issue.[227] Generally, a required medical examination is considered job-related and consistent with business necessity when an employer "has reasonable belief, based on objective evidence, that: (1) an employee's ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition."[228]

Unlike other terms in the ADA, "essential job functions" and "direct threat" are actually defined by law.[229] Factors considered to determine whether a job function is essential include, but are not limited to: whether the reason the position exists is to perform that function, whether there are a limited number of employees available who can perform that job function, and whether the position is highly

220. *Id.*; 42 U.S.C. § 12112(d)(2)–(3).
221. EEOC Enforcement Guide, *supra* note 203; 42 U.S.C. § 12112(d)(2).
222. EEOC Enforcement Guide, *supra* note 203; 42 U.S.C. § 12112(d)(3).
223. EEOC Enforcement Guide, *supra* note 203; 42 U.S.C. § 12112(d)(3).
224. EEOC Enforcement Guide, *supra* note 203; 42 U.S.C. § 12112(d)(4)(a)–(b).
225. 42 U.S.C. § 12112(d).
226. *Id.* § 12112(d)(4)(a)–(b).
227. EEOC Enforcement Guide, *supra* note 203; 42 U.S.C. § 12112(d).
228. EEOC Enforcement Guide, *supra* note 203.
229. 29 C.F.R. § 1630.2(n), (r) (2020).

specialized so that the employee is hired for his or her expertise or ability to perform the function.[230]

An employee poses a direct threat when "a significant risk of substantial harm to the health or safety of the individual or others . . . cannot be eliminated or reduced by reasonable accommodation."[231] The law goes on to discuss how to determine whether an employee poses a "direct threat":

> The determination that an individual poses a "direct threat" shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job. This assessment shall be based on a reasonable medical judgement that relies on the most current medical knowledge and/or on the best available objective evidence. In determining whether an individual would pose a direct threat, the factors to be considered include: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm.[232]

The EEOC Enforcement Guide gives a few examples of when an employee may or may not be required to submit to a medical examination under this rule.[233] In one example, the employer received numerous complaints from customers about Richard, a customer service representative for a mail order company, because Richard was displaying symptoms consistent with hearing loss that impeded his ability to process mail orders correctly.[234] Here, the employer would be permitted under the ADA to require Richard to submit to a medical examination.[235] In another example, the employer was not permitted to require the employee to submit to a medical examination because allegations of the employee's condition were based on unsubstantiated rumors from another employee.[236]

In limited circumstances, employers also may require periodic medical examinations of employees.[237] The EEOC cautions that periodic medical examinations may only be required for employees in positions affecting public safety, and only if the medical examinations are narrowly tailored to address specific job-related concerns.[238] For example,

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230. *Id.* § 1630.2(n).
231. *Id.* § 1630.2(r).
232. *Id.*
233. EEOC Enforcement Guide, *supra* note 203.
234. *Id.*
235. *Id.*
236. *Id.*
237. *Id.*
238. *Id.*

a private security company may require its armed security officers to take periodic blood pressure and stress tests if it is concerned that an officer may have a sudden stroke while attempting to pursue a fleeing criminal.[239] An employer may not, however, require a police department to periodically test its officers for HIV because a diagnosis of HIV does not result in an inability or impaired ability to perform the essential functions of a police officer that would result in a direct threat.[240]

Though there is an increasing need for stronger legal and internal safeguards against the risks posed by aging surgeons facing cognitive and physical decline, policies and programs aimed to mitigate those risks are subject to legal considerations under the ADEA and ADA.[241] Such policies and programs must comply with both laws and must not otherwise discriminate against elderly surgeons.[242] The following subsection will discuss case law challenging medical testing in other fields and distinguish the cases from potential policies and programs specifically tailored to elderly surgeons.

3. CASE LAW DISCUSSING MEDICAL TESTING

The two prominent cases that are often cited by practicing attorneys as indicators that courts would not uphold individual testing for surgeons over a certain age are *Epter v. New York* and *EEOC v. Commonwealth of Massachusetts*.[243] Yet, these two cases are far from dispositive. The facts of each case are easily distinguishable from any fact pattern that would potentially arise from individual testing of elderly surgeons.[244]

Epter arose out of a plaintiff's claim that the New York Transit Authority ("TA") did not promote him from railroad clerk to station supervisor because he refused to submit to an electrocardiogram ("EKG") test.[245] The TA had a policy of requiring applicants for that specific position to submit to a battery of tests including urine screening, blood

239. *Id.*
240. *Id.*
241. 29 U.S.C. § 623 (2019); 42 U.S.C. § 12112.
242. 29 U.S.C. § 623 (2019); 42 U.S.C. § 12112.
243. *See* Grandjean & Grell, *supra* note 11; McCudden, *supra* note 156; Epter v. N.Y. Transit Auth., 127 F. Supp. 2d 384 (E.D.N.Y. 2001); EEOC v. Comm. of Mass., 987 F.2d 64 (1st Cir. 1993).
244. *Compare* Epter, 127 F. Supp. 2d, and EEOC v. Comm. of Mass., 987 F.2d, *with* Complaint, EEOC v. Yale New Haven Hospital, No. 3:20-cv-00187 (D. Conn. filed Feb. 11, 2020).
245. Epter, 127 F. Supp. 2d at 385.

pressure, vision and hearing, and an EKG if they displayed risk factors for a cardiac event or were over the age of forty.[246] The doctor that administered the tests explained to Mr. Epter that the EKG was necessary because the station supervisor job was more physically strenuous than the railroad clerk job, which was mostly sedentary.[247] Specifically, the station supervisor's duty was to supervise the cleaning crew.[248]

First, the Court found that having a heart condition would neither prevent an employee from carrying out this job duty nor would a lack of physical preparedness for this particular job pose a danger to the general public.[249] Second, the Court found that individual testing of all employees, rather than the age classification in use, would not be impractical or costly.[250] Then, the Court ran into the BFOQ second-prong conundrum described earlier.[251] In this case, the Court resolved that issue by falling back on the question of whether the age classification is justified as reasonably necessary to the business.[252] In answering this question, the Court noted:

246. *Id.* at 386.

247. *Id.*

248. *Id.* at 390.

249. *Id.*

250. *Id.* ("For example, this is not a case where the medical test in question itself presents a risk to younger patients—which could constitute a possible justification for an age classification. No such justification is adduced here. Indeed, the practicality of individualized testing is evidence by the fact that the TA employs such an approach for all employees under forty: each employee under forty undergoes the regular physical examination that Epter submitted to and only if that examination or a problematic medical history indicates a reason to think that an EKG might be appropriate is an EKG thereupon administered. But once employees turn forty, the EKG is employed across the board. Cost also does not appear to be a factor in the policy.").

251. *Id.* at 391 ("But it should be noted, once again, that the TA insists that the BFOQ exception that salvaged the mandatory retirement policy in *EEOC v. City of East Providence* does not apply in this case at all because of the individualized nature of the testing here. *EEOC v. Massachusetts* refutes this proposition. Just as the employees there were not automatically forced out of their jobs at the age of seventy, but rather, were simply subjected to annual physicals, the employees seeking promotion here are not automatically denied but are merely forced to undergo an additional procedure that is not administered to those younger than forty. This procedure is no more 'individualized' than was the procedure at issue in the First Circuit case. In much the same way that it would be impermissible to require all men but only women with known medical conditions to take an EKG for the Station Supervisor, Level I position, it would make a mockery of the notion of individualized testing to take it to mean testing all those over a certain age and only some of those under it on the evidence presented by the TA here.").

252. *Id.* ("While medical testing all those above a certain age is, perhaps, a practice less noxious under the ADEA than firing outright or automatically refusing promotion to those over that age, a facial age classification is still involved, and that age

> To put the question sharply, what exactly would happen if a Station Supervisor, Level I were to suffer an unexpected heart attack? While such an event would unquestionably be more than a small inconvenience to the individual himself—but, of course, this is true for any person who has a heart attack while working anywhere and cannot, without more, constitute a justification for age discrimination—there is no indication in this record that a great danger would befall either the TA's operations or the general public. The same certainly cannot be said of a police officer who collapses in the line of duty.[253]

Thus, though the Court certainly had (questionable) opinions in dicta about the BFOQ second-prong conundrum, the outcome of *Epter* did not actually rely on resolving this issue.[254] Instead, Mr. Epter's fate rested on the determination that being a Station Supervisor did not invoke viable concerns for public safety.[255] In contrast, to say that the job of a surgeon does not invoke legitimate public safety concerns would be incredibly disingenuous for obvious reasons.

The *Epter* court also heavily relied on the First Circuit's holding in *EEOC v. Commonwealth of Massachusetts*.[256] In *EEOC*, the EEOC challenged a Massachusetts state statute that required state employees over the age of seventy to submit to a medical examination by a physician selected by the employees' respective retirement board.[257] This included employees such as librarians.[258] Upon receipt of the physician's report, the retirement board would decide whether the employee could continue employment.[259] The First Circuit rightly struck down this statute under the ADEA.[260] The Court distinguished this case from its holding in *EEOC v. East Providence*, where it upheld mandatory retirement for police officers over the age of sixty.[261] Specifically, the Court explained: "[h]ere, the Commonwealth has not tailored the statute to particular jobs, but rather to all," signaling that individual testing for employees over a certain age may be upheld if narrowly tailored to a specific

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classification has to be justified as being reasonably necessary to the operations of the TA's business in order to withstand scrutiny.").

253. *Id.* at 391–92.
254. *Id.*
255. *Id.*
256. Epter v. N.Y. Transit Auth., 127 F. Supp. 2d 384 (E.D.N.Y. 2001).
257. EEOC v. Commonwealth of Mass., 987 F.2d 64, 66 (1st Cir. 1993).
258. *Id.*
259. *Id.*
260. *Id.* at 71.
261. *Id.* at 73.

profession.[262] It is also important to note that the Commonwealth did not even invoke a BFOQ defense.[263]

The overarching lesson from guidance on the ADEA and ADA is that the more narrowly-tailored and job-related individual medical testing can be, the more likely it is to be compliant under both laws.[264] Despite the opinions of attorneys who cite cases such as *Epter* and *EEOC*,[265] these cases are not sufficiently comparable to the specifics of a mandated individualized medical testing policy for elderly surgeons. Thus, these guidelines and decisions should be considered useful for informing policy rather than a deterrence to making policy at all.

D. Retirement Schemes in Other Professions

As noted above, the idea of retirement schemes based on an employee's age are not new or unique to the medical field. Many occupations are subject to retirement schemes including mandatory retirement, stricter medical testing for senior employees, and enhanced retirement benefit incentives for early retirement.[266] What these occupations have in common and what serves as the rationale for needing such retirement schemes is that these occupations are both psychologically and physically demanding.[267] Airline pilots and law enforcement are examples of such occupations,[268] and their respective policies have been the subject of numerous lawsuits and debates.[269] Because performing surgery is both psychologically and physically demanding, those seeking to craft similar policies or legislation for elderly surgeons may look to schemes in these other occupations for guidance. And though mandatory retirement is not on the table for surgeons because of the AMA's staunch opposition,[270] the lessons from legal challenges to and debates of such policies are important and relevant for any type of policy that invokes concerns of age discrimination.

262. *Id.* (citing Trans World Airlines, Inc. v. Thurston, 469 U.S. 111 (1985)).
263. *Id.*
264. *See generally* EEOC Enforcement Guide, *supra* note 203.
265. Epter v. N.Y. Transit Auth., 127 F. Supp. 2d 384 (E.D.N.Y. 2001); EEOC v. Commonwealth of Mass., 987 F.2d 64, 66 (1st Cir. 1993).
266. ISAACS, *supra* note 10; Fair Treatment for Experienced Pilots Act, Pub. L. No. 110-135, 121 Stat. 1450 (2007).
267. ISAACS, *supra* note 10.
268. *Id.*
269. *Id.*
270. Grandjean & Grell, *supra* note 11.

1. MANDATORY RETIREMENT AND ENHANCED MEDICAL TESTING FOR AIRLINE PILOTS

The history of mandatory retirement and enhanced medical testing for airline pilots over a certain age is not cut-and-dry; regulations have changed over the years due to continued contention in the industry.[271] From 1959 to 2007, federal law required airline pilots to retire at age sixty.[272] This was known as the "Age 60 Rule."[273] Airline pilots shared the same sentiment about the Age 60 Rule as physicians feel about the idea of mandatory retirement.[274] They believed the Age 60 Rule was discriminatory and not fair to experienced professionals who were still in good health past their sixties.[275] Airline pilots frequently challenged the Age 60 Rule in federal court; however, it was consistently upheld.[276] It was not until 2007 that persistent lobbying efforts finally led to the abolition of the Age 60 Rule, which was subsequently replaced with the Fair Treatment for Experienced Pilots Act ("FTEPA").[277]

The FTEPA did not get rid of mandatory retirement completely.[278] Instead, the law raised the mandatory retirement age to sixty-five and implemented several new requirements for airline pilots who wish to continue to fly between ages sixty and sixty-five.[279] First, a pilot between the ages of sixty and sixty-five may only serve as a pilot-in-command on international flights if there is another pilot on the flight crew under the age of sixty.[280] Second, the law requires any pilot over the age of sixty to obtain a first-class medical certificate.[281] A first-class medical certificate is the strictest medical certificate, typically required only for non-commercial airline transporters.[282] It requires re-certification every

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271. Nicholas D. O'Conner, *Too Experienced for the Flight Deck? Why the Age 65 Rule is Not Enough*, 17 ELDER L.J. 375, 376 (2009).

272. *Id.*

273. *Id.*

274. *Id.*

275. *Id.*

276. *Id.* at 378–79.

277. *Id.* at 387.

278. Fair Treatment for Experienced Pilots Act, Pub. L. No. 110-135, 121 Stat. 1450 (2007).

279. *Id.*

280. *Id.*

281. *Id.* (stating though the law "[p]rohibits subjecting pilots to different medical examinations and standards on account of age unless to ensure an adequate level of safety in flight.").

282. Aircraft Owners & Pilots Ass'n, *Airman Medical Certification: Understanding Airman Medical Standards*, AOPA FOUND. (Feb. 2015), https://www.aopa.org/go-fly/medical-resources/airman-medical-certification#.

six months if the pilot is aged forty or older, as well as additional medical testing such as an EKG every year after age 40.[283]

The first-class medical certificate requirements further the goal of consumer safety because applicants must disclose potentially disqualifying medical conditions such as coronary heart disease, mental disturbances, and nervous system dysfunction—and the risk of each of these conditions increases with age.[284] The law also requires all air carriers (individual, private, public, or otherwise)[285] to "evaluate, every six months, the performance of pilots who have attained 60 years of age through a line check of such pilot."[286] A line check is an on-the-job evaluation; pilots are observed to ensure their performance adheres to company and federal protocol and standards.[287] Failure of a line check may result in the end of a pilot's career.[288]

Despite the law's expansion to allow senior pilots to continue flying past age sixty with increased medical safeguards, many pilots are unhappy with the FTEPA and are calling for it to be repealed.[289] Though the various reasons for disapproval differ, where the schools of thought agree is perhaps the most defining point of contention: whether age sixty or sixty-five, critics believe that *any* age limit is arbitrary and discriminatory against capable senior pilots.[290] Surgeons would certainly feel the same way.[291]

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283. *Id.*

284. *Id.*; Stacy Sampson, *Risk Factors for Coronary Artery Disease (CAD)*, HEALTHLINE (Sept. 16, 2018), https://www.healthline.com/health/coronary-artery-disease/risk-factors; *The State of Mental Health and Aging in America*, CDC (2008), https://www.cdc.gov/aging/pdf/mental_health.pdf; *Aging changes in the nervous system*, MEDLINEPLUS, https://medlineplus.gov/ency/article/004023.htm (last visited Oct. 25, 2021).

285. *Definitions: Part 139 Airport Certification*, FAA (Sept. 21, 2020, 5:03 PM). https://www.faa.gov/airports/airport_safety/part139_cert/definitions/#.

286. Fair Treatment for Experienced Pilots Act, Pub. L. No. 110-135, 121 Stat. 1450 (2007).

287. Chip Wright, *Line Checks*, AOPA FOUND. (Nov. 8, 2011), https://blog.aopa.org/aopa/2011/11/08/line-checks/.

288. *Id.*

289. O'Conner, *supra* note 271, at 399; Jeff Orkin, *Fair Treatment for Experienced Pilots Act–All Good Things Really Do Come to an End*, 73 J. AIR L. COM. 579, 609–10 (2008).

290. O'Conner, *supra* note 271, at 376–77; Orkin, *supra* note 289, at 610.

291. Blasier, *supra* note 1; *see generally* Grandjean & Grell, *supra* note 11, at 357–58.

1. LEGAL CHALLENGES TO THE FTEPA

The several legal challenges to the FTEPA mainly allege that the mandatory retirement provision violates the ADEA and the Equal Protection Clause of the Fifth Amendment.[292] Though these cases have not reached the U.S. Supreme Court, federal courts agree that the FTEPA is constitutional and does not violate the ADEA.[293] The provisions of the FTEPA, which increased medical requirements and on-the-job performance evaluation for pilots over age sixty, have not been challenged in court.[294]

The Equal Protection claims have failed because the Supreme Court does not consider age a suspect classification.[295] A suspect classification "refers to a class of individuals that have been historically subject to discrimination," such as those belonging to a certain race or religion.[296] In declining to deem age a suspect classification, the Supreme Court explained that "[w]hile the treatment of the aged in this Nation has not been wholly free of discrimination, such persons . . . have not experienced a 'history of purposeful unequal treatment' or been subjected to unique disabilities on the basis of stereotyped characteristics not truly indicative of their abilities."[297] Since age is not a suspect classification, any law which purportedly discriminates based on age is subject to rational basis review.[298] To analyze a law under rational basis review, the Court employs a two-prong test that asks whether (1) the government has the power or authority to regulate the particular area in question, and (2) there is a rational relationship between the government's objective and the means it has chosen to achieve it.[299] In applying

292. *See, e.g.*, Avera v. Airline Pilots Ass'n Intern., No. 10-14905, 2011 WL 3476824 (11th Cir. 2011); Jones v. Air Line Pilots Ass'n, 713 F. Supp. 2d 29 (D.D.C. May 25, 2010); Yap v. Slater, 128 F. Supp. 2d 672 (D. Haw. 2000); Dungan v. Slater, 252 F.3d 670 (3d Cir. 2011).

293. *Id.*

294. *See* O'Conner, *supra* note 271 (explaining why the age 65 rule should be abolished and it should be replaced with the rigorous medical exams that are already in place for pilots.); *see also* Pilot's Guide To Medical Certification, AOPA, https://www.aopa.org/training-and-safety/students/presolo/special/pilots-guide-to-medical-certification (last visited Oct. 23, 2021) (explaining how the medical certification process works for pilots and what each certification allows the pilot to do).

295. Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 83 (2000).

296. LEGAL INFO. INST., *Suspect classification*, CORNELL L. SCH., https://www.law.cornell.edu/wex/suspect_classification# (last visited Oct. 23, 2021).

297. Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 313 (1976).

298. Kimel, 528 U.S. at 83–84.

299. Leib v. Hillsborough Cnty. Pub. Transp. Comm'n, 558 F.3d 1301, 1306 (11th Cir. 2009).

the rational basis test, the Supreme Court consistently upholds mandatory retirement schemes for certain occupations.[300]

On the spectrum of age-based laws, mandatory retirement is a far more daunting and restrictive means of achieving a goal than an individualized medical testing scheme would be. The fact that courts regularly uphold mandatory retirement schemes is a positive indication that an individualized medical testing scheme for elderly surgeons will also likely be upheld.

E. Other Considerations

There are far too many considerations that go into crafting a law to include in this Note, but the following subsection will address the two most important considerations not yet discussed. First, this subsection will analyze the triumphs and pitfalls of the peer review process, which is currently the primary mechanism for assessing physician competency.[301] Next, state medical boards and their legal authority will be analyzed in the context of being the best candidate body to regulate and enforce individualized medical testing for elderly surgeons.

1. LESSONS FROM THE PEER REVIEW PROCESS

Those familiar with hospital administration may be wondering why additional screening for elderly physicians is necessary when the peer review process already exists as a quality assurance measure. For those unfamiliar, peer review programs evaluate the effectiveness of a healthcare system's structures, process, and physicians.[302] The process was first developed in the early twentieth century by the ACS as a means of defining standards of care for surgeons.[303] Since 1952, all hospitals in the United States are required by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to administer peer review to be accredited.[304]

300. *See, e.g.*, Gregory v. Ashcroft, 501 U.S. 452 (1991); Vance v. Bradley, 440 U.S. 93 (1979); Mass. Bd. of Ret. v. Murgia, 427 U.S. 307 (1976).
301. Lily Hsia, *Quality Assurance and Peer Review*, 29 J. NURSE-MIDWIFERY 233, 233 (1984).
302. *Id.*
303. Dinesh Vyas & Ahmed E. Hozain, *Clinical Peer Review in the United States: History, Legal Development and Subsequent Abuse*, 20 WORLD J. GASTROENTEROLOGY 6357–58 (2014).
304. *Id.*

The peer review process is insufficient to protect against incompetent elderly surgeons because, despite the quality-minded intent, well-documented and litigated abuse of the process has undermined legitimate peer reviews.[305] Such bad-faith reviews are so prevalent that they have earned the moniker "sham peer review."[306] Sham peer reviews are "characterized as a review called for by either a single, or group of physicians, conducted in order to lead to adverse action taken by the review committee."[307] In other words, a physician or group of physicians with a personal vendetta or who seek to eliminate market competition may recommend termination of another physician based on fabricated incompetency where none actually exists.[308] Before 1986, sham peer reviews could be successfully litigated.[309] Unfortunately, this system of checks-and-balances changed following the landmark case of *Patrick v. Burget* and the reactionary Health Care Quality Improvement Act of 1986 ("HCQIA").[310]

In *Patrick*, Dr. Patrick had his surgical privileges terminated by his new employer when his former employers recommended Dr. Patrick be subject to peer review for irresponsible physician behavior.[311].Dr. Patrick subsequently sued the committee under the Sherman Antitrust Act for using the peer review process to reduce competition rather than for legitimate patient safety purposes.[312] He was awarded a $2.2 million verdict after it was found that the reviewing committee, which was chaired by a partner at Dr. Patrick's former employer, fabricated evidence against Dr. Patrick in order to stifle competition.[313] The verdict was eventually upheld by the U.S. Supreme Court.[314] Following *Patrick*, many physicians became reluctant to participate in peer review out of fear of litigation.[315] To reassure peer reviewers, Congress subsequently enacted the HCQIA, which gives peer reviewers immunity from private litigation following peer reviews.[316] With the slew of litigation challenging the HCQIA being largely unsuccessful, physicians are

305. *Id.*
306. *Id.* at 6359.
307. *Id.*
308. *Id.*
309. *Id.*
310. *Id.*
311. *Id.*
312. *Id.* at 6358.
313. *Id.*
314. *Id.*
315. *Id.*
316. *Id.*

understandably skeptical and unwilling to participate in the process.[317] Conversely, many physicians are reluctant to give legitimate negative reviews of their esteemed colleagues, leading some to fear creation of even very minimal standards for competency.[318]

Elderly surgeons have a right to be weary of individual testing programs that share aspects of the peer review process. Well-crafted policy can avoid concerns such as sham reviews, however, as the problem with peer review lies in practice rather than theory.[319] For further example, the fact that peer reviews are typically conducted by one's own colleagues rather than objective third parties lends itself to concerns of self-interest and leniency.[320] In addition, courts across the country have routinely upheld outcomes of peer review processes even when there is a proven conflict of interest.[321]

There are positive aspects of the peer review process as well. Many states have statutory peer review privileges which protect information retained by health care providers regarding critical incidents, physician competency, quality improvement measures, etc.[322] These privileges protect the public anonymity of physicians subject to investigations and adverse actions—this is why Dr. Doe is only known as Dr. Doe.[323] Preserving these privileges for an individual surgeon testing program has been cited by both the AMA and JCAHO as critical for maintaining privacy and dignity.[324] Though some argue that consumers should be able to access information about peer review investigations and adverse actions, access to this information may be unduly prejudicial to a surgeon's business practice, particularly when the investigations and adverse actions are based on fabricated evidence.[325] Thus, future policy and legislation regarding individualized testing of elderly

317. *Id.*; *Landmark Cases*, HCQIA, https://web.archive.org/web/20210424233233/http://www.hcqia.net/laws.htm (last visited Oct. 23, 2021).

318. Skip Freedman, *Best Practices for Enhancing Quality*, PATIENT SAFETY & QUALITY HEALTHCARE (Jan./Feb. 2007), https://www.psqh.com/janfeb07/peer.html.

319. *See generally* Vyas & Hozain, *supra* note 303.

320. Freedman, *supra* note 318.

321. Landmark Cases, *supra* note 317.

322. Laurie K. Miller, *Defending the Peer Review Privilege: Guidance for Health Care Providers and Counsel after Wheeling Hospital*, 120 W. VA. L. REV. ONLINE 34 (Nov. 17, 2017), https://wvlawreview.wvu.edu/west-virginia-law-review-online/2017/11/17/defending-the-peer-review-privilege-guidance-for-health-care-providers-and-counsel-after-wheeling-hospital.

323. *Id.*

324. AMA 2015 Report, *supra* note 26.

325. Freedman, *supra* note 317; Miller, *supra* note 322.

surgeons should heed the warnings, but draw on the quality-minded intent and positive aspects of the peer review process.

2. THE ROLE OF STATE MEDICAL BOARDS AND MEDICAL PRACTICE ACTS

While the regulation of medical practice in the United States can be a confusing hodgepodge of federal and state laws,[326] state medical boards bear the brunt of physician licensing and discipline.[327] State medical boards derive their authority from state laws commonly known as "medical practice acts."[328] All fifty states have some variation of these acts.[329] These laws expire regularly in order to ensure the laws stay up-to-date with current practice.[330] Some states' medical practice acts also include standards and mechanisms for reporting impaired physicians.[331] When a physician faces disciplinary action by the board, he or she often is required to undergo testing, training, and rehabilitation to have their license reinstated.[332] The respective state boards set these standards.[333]

As follows, there is no national standard for how a state chooses to regulate its physicians.[334] The Federation of State Medical Boards ("FSMB") and Department of Health and Human Services periodically publish guidelines for state medical boards and state legislatures, but these guidelines are unenforceable.[335] Recently though, there has been an increased call for easy state-to-state mobility of physicians to meet the needs of the increasing frequency of public health emergencies such

326. Bob Kocher, *Doctors Without State Borders: Practicing Across State Lines*, HEALTH AFFAIRS (Feb. 18, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140218.036973/full/.

327. Drew Carlson & James Thompson, *The Role of State Medical Boards*, 7 J. ETHICS 311–14 (2005).

328. *Id.*

329. *Id.*; La Couture, *supra* note 125.

330. *What is the Medical Practice Act and Why is it Important?*, ILL. ST. MED. SOC'Y (2017) [hereinafter ISMS], https://www.isms.org/ISMS.org/media/ISMSMediaLibrary/Resources/MedicalPracticeActPrimer.pdf; *Guidelines for the Structure and Function of a State Medical and Osteopathic Board*, FED'N ST. MED. BD. (Apr. 2018) [hereinafter FSMB], https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf.

331. ISMS, *supra* note 330.

332. Carlson & Thompson, *supra* note 327; ISMS, *supra* note 330.

333. Carlson & Thompson, *supra* note 327; ISMS, *supra* note 330.

334. Kocher, *supra* note 365.

335. *See, e.g.*, FSMB, *supra* note 330; U.S. DEP'T OF HEALTH & HUM. SERVS., *Federal Initiatives to Improve State Medical Boards' Performance*, OFF. INSPECTOR GEN. (1993).

as the COVID-19 pandemic.[336] In 2017, the FSMB launched the Interstate Medical Licensure Compact, a voluntary compact between state medical boards which aims to streamline the process for physicians applying for medical licenses in multiple states.[337] On October 30, 2020, a bipartisan bill was introduced in the U.S. House of Representatives to "condition receipt of State funding from the Bureau of Health Workforce on adoption by the State of the Interstate Medical Licensure Compact."[338] Many believe this is a step toward a robust interstate or single national licensing scheme.[339] Such a scheme would likely be modeled off the various medical practice acts.[340]

The current peer review process is not the best mechanism for assessing the competency of elderly surgeons as its legitimacy is compromised.[341] Yet, there are positive aspects of peer review that could be replicated in a different policy or program administered by state medical boards. Such policy or program may eventually become federal policy or even implemented on a national scale.

IV. Recommendation

There is a clear need for better measures to address the problem of the aging surgeon. With the number of elderly surgeons expected to grow, so too will costly medical malpractice claims.[342] As discussed, this is due to a combination of cognitive and physical decline and is compounded by technological advancements in medicine.[343] In theory, the current prevailing mechanism of self-policing is meant to identify surgeon competency issues before serious patient safety problems arise.[344] But self-policing does not work.[345] Younger medical staff members do not raise concerns about senior surgeons due to reverence and "snitch

336. Kocher, *supra* note 326; La Couture, *supra* note 125; Kat Jercich, *House bill would compel states to join the Interstate Medical Licensure Compact*, HEALTHCARE IT NEWS (Nov. 25, 2020), https://www.healthcareitnews.com/news/house-bill-would-compel-states-join-interstate-medical-licensure-compact.

337. Eric Wicklund, *New Telehealth Bill Would Penalize States Who Don't Join Licensure Compact*, MHEALTH INTEL. (Nov. 24, 2020), https://mhealthintelligence.com/news/new-telehealth-bill-would-penalize-states-who-dont-join-licensure-compact.

338. H.R. 8723, 116th Cong. (2020).

339. Kocher, *supra* note 326; Jercich, *supra* note 336.

340. Kocher, *supra* note 326.

341. Blasier, *supra* note 1.

342. *See infra* Section II.A.

343. *See id.*

344. *See infra* Section II.B.

345. Span, *supra* note 71.

guilt."[346] Surgeons themselves are poor judges of their competency and, understandably, do not want to be told when to retire.[347] But there can and should be more safeguards in place. Without changing the status quo, dangerous clinical outcomes and increased cost to consumers *and* providers will continue to rise.[348]

One potential solution is a federal mandatory retirement law for surgeons over age sixty. A federal mandatory retirement law would be an easy fix to the dual problems of infrequent medical license revocations and state-hopping by those whose licenses do get revoked. The law would likely be modeled after the FTEPA since the FTEPA consistently has been upheld in court.[349] It could similarly even include provisions for continued employment between age sixty and sixty-five with increased medical assessments, line checks, and the requirement that surgeons over age sixty be accompanied by younger surgeons during operations.[350]

Such a law, however, would certainly be faced with the same criticism as the FTEPA.[351] Namely, this one-size-fits-all solution is unfair and unnecessary for those who can demonstrate continued competency past the arbitrarily-picked age sixty.[352] A mandatory retirement law would raise practical questions as well. Particularly with respect to the provision of a senior surgeon being accompanied by a younger surgeon, many may cite the nationwide physician shortage as a hurdle.[353] In addition, the AMA has made it very clear that it does not support a mandatory retirement policy.[354] This is a problem because the AMA does not just recommend policy—it lobbies hard for its policies as well.[355] The lobbying arm of the AMA is enormously successful,

346. Okwerekwu, *supra* note 6.

347. Blasier, *supra* note 1.

348. Charles Kolodkin, *The Government Weighs in: What's Causing Increased Medical Malpractice Premium Rates*, IRMI (Oct. 2003), https://www.irmi.com/articles/expert-commentary/whats-causing-increased-medical-malpractice-premium-rates.

349. *See, e.g.*, Avera v. Airline Pilots Ass'n Intern., No. 10-14905, 2011 WL 3476824 (11th Cir. Aug. 9, 2011); Jones v. Air Line Pilots Ass'n, 713 F. Supp. 2d 29, 29 (D.D.C. May 25, 2010); Yap v. Slater, 128 F. Supp. 2d 672 (D. Haw. 2000); Dungan v. Slater, 252 F.3d 670 (3d Cir. 2011).

350. Fair Treatment for Experienced Pilots Act, Pub. L. No. 110-135, 121 Stat. 1450 (2007).

351. *See generally id.*

352. *See generally* AMA 2018 Report, *supra* note 110.

353. Patrick Boyle, U.S. *physician shortage growing*, ASS'N AM. MED. COLLS. (June 26, 2020), https://www.aamc.org/news-insights/us-physician-shortage-growing.

354. AMA 2018 Report, *supra* note 110.

355. La Couture, *supra* note 125.

particularly where medical licensing is concerned.[356] Thus, any proposal that would affect a surgeon's practice—especially his or her business practice—would likely be futile without the AMA's support. Legislators wishing to enact a mandatory retirement law for surgeons would face an uphill battle against the AMA.[357]

This is why individualized cognitive and physical testing for elderly surgeons is the best emerging solution.[358] Despite general agreement by the medical community that this option is viable, there is not a consensus on how and when such tests should be administered, whether policies should be determined by individual healthcare systems or lawmakers, and the legality of any such policies.[359] This is further complicated by the conflicting opinions of various stakeholders—namely patients, surgeons, and healthcare systems.[360] Therefore, this Recommendation is twofold and is intended as a compromise between the various positions. First, individualized testing should be administered by independent third parties, beginning at the AMA and ACS's recommended ages of sixty-five to seventy.[361] Second, mandatory periodic individual testing should be incorporated into each state's medical practice act.

A. Logistics

There are three logistical questions to answer when thinking about how to design and implement an individualized testing program. One, what will the battery of tests look like? Two, at what age should testing begin? And three, how should tests be designed to protect against bias and fraud? The following section will address each of these three questions.

1. WHAT TESTS SHOULD BE ADMINISTERED

The testing battery should be as narrowly tailored as possible to the competencies required for a particular procedure or surgical

356. *Id.*
357. *See generally id.*
358. *See* Greta V. Bernier & Jaime E. Sanchez, *Surgical Simulation: The Value of Individualization*, SOC'Y AM. GASTROINTESTINAL ENDOSCOPIC SURGEONS (May 10, 2016), https://www.sages.org/publications/tavac/surgical-simulation-value-individualization/; *see also* Burling, *supra* note 8.
359. *See* Burling, *supra* note 8.
360. *See id.*
361. AMA 2015 Report, *supra* note 26; AMA 2018 Report, *supra* note 110.

specialty. This is because no two surgeries are alike.[362] It would be a waste of time and resources and would be potentially discriminatory to test surgeons on competencies unneeded or less important for their specialty. For example, hand-eye precision is far more necessary for Surgeon A, who must immediately remove a blockage from a woman's internal carotid artery—which has an average diameter of 4.66 millimeters to 5.11 millimeters[363]—than for Surgeon B, who is performing an elective mole removal. To force Surgeon B to perform the same test to the same standards as Surgeon A when Surgeon B's procedures do not call for such acuity would waste time, resources, and would discriminate against Surgeon B. Conversely, allowing Surgeon A to only take the less-stringent test designed for Surgeon B would also be inappropriate, as the result may miss key failures in competencies necessary for Surgeon A's specialty.

While this Note has focused on the age-specific risks of technological advances in medicine, there are benefits of these advances as well. Multiple companies currently offer surgical simulators for minimally invasive and interventional procedures designed with competency training in mind.[364] One such simulator is the Imperial College Surgical Assessment Device ("ICSAD"), which uses an electromagnetic field generator attached to the surgeon's hands to assess a range of laparoscopic and open surgical tasks.[365] Similar machines are available for optical motion tracking as well,[366] though some surgeons may only need a basic eye exam.

The cost of purchasing and maintaining simulation and other testing equipment initially may seem daunting. One study found that the "average cost to start a well-equipped [surgical simulation] lab is estimated at $450,000 (ranging from $100,000 to several million dollars). . . . In addition, a simulation center requires between $12,000 to $300,000 annually for consumable materials, such as surgical supplies, maintenance, upgrades as well as other administrative overhead

362. *See Common Surgical Procedures*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/common-surgical-procedures (last visited Oct. 23, 2021).

363. Jaroslaw Krejza et al., *Carotid Artery Diameter in Men and Women and the Relation to Body and Neck Size*, 37 STROKE 1103–05 (2006).

364. Badash, *supra* note 167.

365. Krishna Moorthy et al., *Clinical Review: Objective Assessment of Technical Skills in Surgery*, 327 BRIT. MED. J. 1032–37, 1034 (2003).

366. *Id.* at 1034.

costs."[367] But even the top-dollar estimate is significantly less than medical malpractice payouts.[368] In 2018 alone, approximately $4,031,987,700 was paid to plaintiffs in medical malpractice lawsuits, with an average payment of $348,065.[369] This represented a 2.91% increase in payouts from the previous year.[370] Surgical errors were the second-most alleged claims, comprising 21.4% of all claims in 2018.[371] Using surgical simulations and other assessments to identify and address surgeons with competency issues before adverse clinical outcomes arise should be considered a cost-saving mechanism. Medical malpractice insurers and healthcare systems alike may even consider footing the bill.

2. WHEN TO BEGIN TESTING

It is crucial for both ethical and legal considerations that the age in which individual testing begins is based on scientific evidence and consensus rather than being arbitrarily picked by lawmakers.[372] Arbitrary retirement age selection by lawmakers is one of the biggest complaints of airline pilots calling for repeal of the FTEPA.[373] Fortunately, the AMA has spoken on this issue.[374] Specifically, the AMA's 2015 Report on Competency and the Aging Physician cites a survey which concludes, "[a]mong the respondents, which included staff from physician assessment centers, attorneys and state medical board members, 72 percent recommended that screening begin at age 65 or 70."[375] The ACS has recommended the same.[376]

In accordance with the AMA and ACS's recommendation, testing should begin at age sixty-five.[377] Following the AMA's

367. Greta V. Bernier & Jaime E. Sanchez, *Surgical Simulation: The Value of Individualization*, SOC'Y AM. GASTROINTESTINAL & ENDOSCOPIC SURGEONS (May 10, 2016), https://www.sages.org/publications/tavac/surgical-simulation-value-individualization/.

368. *Compare* Bernier & Sanchez, *supra* note 367, *with* Anjelica Cappellino, *Medical Malpractice Payout Report for 2018*, EXPERT INST., https://www.expertinstitute.com/resources/insights/medical-malpractice-payout-report-for-2018/# (last updated June 25, 2020).

369. Cappellino, *supra* note 368.

370. *Id.*

371. *Id.*

372. O'Conner, *supra* note 271.

373. *Id.*

374. AMA 2015 Report, *supra* note 26.

375. *Id.*

376. AMA 2018 Report, *supra* note 110.

377. Carol Berkowitz, *Competency of Senior Physicians*, Reports of the Council on Medical Education, AM. MED. ASS'N (2018).

recommendation is highly advised for two reasons mentioned earlier. First, the AMA is the largest constituency of physicians in the United States.[378] Any policy affecting its constituents should be informed and approved by the AMA on their behalf. This would be consistent with the medical community's continued desire to self-police.[379] Second, proponents of this policy would still need to contend with the AMA's lobbying arm. The AMA would be hard-pressed to lobby against a policy based on their own recommendation.

3. MINIMIZING BIAS AND FRAUD

Another important aspect of any individualized cognitive and physical testing scheme is the need for independent and unbiased administrators.[380] Otherwise, the program would be vulnerable to the same potential abuse seen with the peer review process. There are many ways in which independent and unbiased reviews can be achieved.

First, tests should be administered and reviewed as anonymously as possible. While the nature of cognitive and physical testing necessarily requires face-to-face interaction,[381] there is no reason why administrators would need to know personal identifiers of the testee. The only information administrators need to know to make a proper medical assessment is the testee's age, relevant health history and health-related demographic information, and the procedures that the surgeon performs.[382] Personal identifiers such as where the surgeon works, where they were trained or went to school, and even the surgeon's name is irrelevant to a strictly medical assessment of one's cognitive and physical abilities.[383]

Second, conflicts of interest must be avoided.[384] Any potential conflicts of interest could be easily avoided by having the relevant

378. *ABOUT,* AM. MED. ASS'N, https://www.ama-assn.org/about (last visited Oct. 23, 2021).

379. Berkowitz, *supra* note 377, at 112.

380. *See generally* Vyas & Hozain, *supra* note 303 (discussing abuse of the peer review system due to reviewer bias and ulterior motives).

381. Dinchen Jardine et al., *Evaluation of Surgical Dexterity During the Interview Day: Another Factor for Consideration*, 7 J. GRADUATE MED. EDUC. 234–37 (2015); *see* Julia Ries, *Here's How Cognitive Tests Work and What They Look For*, HEALTHLINE (July 22, 2020), https://www.healthline.com/health-news/heres-how-cognitive-tests-work-and-what-they-look-for#How-do-neuropsychological-assessments-work.

382. *See* Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systematic Review*, 18 BMC MED. ETHICS 1–18 (2017).

383. *Id.*

384. *See* Vyas & Hozain, *supra* note 303.

governing body send the testee the names of the administrators and reviewers ahead of their testing date and allow the testee to notify the governing body of any potential conflicts. Conversely, administrators and reviewers would be under a legal obligation to report any conflicts should the identification of the testee be compromised. Since 100% anonymity is impossible, there would be the added safeguard of allowing the testee to be accompanied and observed throughout their test by a trusted peer or representative. This is a common practice for personal injury plaintiffs undergoing independent medical examinations.[385] This buddy-system ensures there is a witness in the event of complaints of inappropriate behavior by the examining physician.[386] The same conflicts check process as noted above would be used for the buddy. Then, a comprehensive report with recommendations would be transmitted to the surgeon's respective employer.

B. State Laws

Though competency issues for elderly surgeons is a problem nationwide, laws mandating individualized testing should be determined by individual states. The primary reason for the preference for state laws over a federal law is that the framework already exists in each state through their respective medical practice acts and medical boards.[387] Since medical practice acts expire regularly for the exact purpose of constant revision, it would be practical and efficient to write in a provision for mandated individualized testing that could be frequently revised to reflect practical, legal, and technological developments.[388] The law would incorporate the specific components of testing and bias and fraud reduction discussed above and would require testing to begin at age sixty-five. Test administration and review would fall under the purview of each state's medical boards pursuant to the authority already conferred by the acts.[389]

Drawing on the positive aspects of the peer review process, the law should contain privileges to protect the anonymity of a surgeon's test results and any recommendations and adverse actions that follow.

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385. David Goguen, *Tips for the Independent Medical Examination (IME) in an Injury Claim*, NOLO, https://www.nolo.com/legal-encyclopedia/tips-the-independent-medical-examination-ime-injury-case.html (last visited Oct. 23, 2021).
386. *Id.*
387. Carlson & Thompson, *supra* note 327.
388. *See generally* ISMS, *supra* note 330.
389. *See generally* Carlson & Thompson, *supra* note 327; ISMS, *supra* note 330.

While this may be considered a blow to the plaintiff's bar and consumer interest groups, one must consider the factors that lead surgeons to unsafely practice past their prime in the first place—namely lack of reporting, misperception of one's own abilities and the desire to retire with dignity.[390] Thus, this should be considered a fair compromise of conflicting interests.

In addition, laws should expressly deny or limit immunity for test administrators and reviewers. There is no reason to believe any provision like the HCQIA would result differently for the process of individual competency testing for elderly surgeons.[391] In its place, a formal grievance and appeal process would take place through state medical boards to reserve litigation only for the most egregious cases. These medical boards even can consider requiring service as an administrator or reviewer as a condition of license renewal or board certification. This option may be viewed by some as drastic and difficult to implement; however, the selection process and time commitment required actually would be similar to, yet a lot less intensive than, how the United States selects citizens for jury duty.[392]

Lastly, legal challenges to such a law under the ADEA, ADA, and the Equal Protection Clause are expected, but carefully crafted policies likely will pass legal scrutiny.[393] Proponents of such a law need not be discouraged by cases such as *Epter* and *EEOC* as both cases concerned policies that were overly-broad and inappropriate to achieve their aims.[394] Even skeptics of mandated individualized testing acknowledge that tests that are narrowly-tailored to specific job duties may withstand legal challenges, particularly under the ADA and Equal Protection Clause.[395] As discussed above, technological advances in the field of medicine that did not exist at the time *Epter* and *EEOC* were decided will make it increasingly easier to narrowly tailor tests to specific job duties. Proponents also should be encouraged by the fact that the enhanced medical testing for senior pilots is generally accepted (even by

390. *See infra* Section I.B.

391. Ilene N. Moore, *Screening Older Physicians for Cognitive Impairment: Justifiable or Discriminatory?*, 28 HEALTH MATRIX 95, 173 (2018).

392. *See Learn About Jury Service*, U.S. CTS., https://www.uscourts.gov/services-forms/jury-service/learn-about-jury-service (last visited Dec. 10, 2021).

393. McCudden, *supra* note 156.

394. Epter v. N.Y. City Transit Authority, 216 F.Supp. 2d 131 (E.D.N.Y. 2002); EEOC v. Commonwealth of Mass., 987 F.2d 64 (1st Cir. 1993).

395. McCudden, *supra* note 156.

those against the FTEPA) and has not been challenged in court.[396] Thus, the thorniest legal issue to be decided is the second-prong BFOQ conundrum of the ADEA.[397] Lawmakers must pay close attention to what, if anything, the District Court of Connecticut decides in the Yale case, even if its decision is non-binding on other jurisdictions.

V. Conclusion

Dr. Doe succumbed to the cognitive and physical decline associated with aging.[398] His clerks and medical staff succumbed to 'snitch guilt.'[399] Had Dr. Doe been assessed and tested for cognitive and physical competencies related to the abdominal surgeries he performed, his competency issues that led to abnormally bloody surgeries would have come to light sooner. He could have worked with his employer to find a dignified solution that worked for both—perhaps transitioning to a teaching or administrative role, perhaps retirement. Unfortunately, that did not happen and his patient died.[400]

The problem of the aging surgeon is not new.[401] But technological advances in the medical field and lack of patient safeguards exacerbated the issue to the point where lawmakers and the medical community alike are finally discussing action. Any future action, however, will inevitably be complicated by competing interests of various stakeholders including surgeons, patients, lawmakers, and healthcare systems. Mandatory individualized cognitive and physical testing for surgeons beginning at age sixty-five, regulated at the state level, is a fair solution for all.

396. O'Conner, *supra* note 271.
397. *Id.*
398. Blasier, *supra* note 1.
399. Blasier, *supra* note 1; Okwerekwu, *supra* note 6.
400. Blasier, *supra* note 1.
401. *Id.*