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Promoting Fairness in Screening Programs for Late-Career Practitioners

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Late-career physicians (LCPs) are an integral part of the U.S. medical workforce. Nearly a quarter of practicing physicians in the United States are over 65 years of age, and they are serving at a time of overall physician scarcity.[1,2] Older physicians bring valuable wisdom and expertise to patient care, but many will experience cognitive and physical decline that may affect their clinical skills.[3,4] Interest has grown among hospitals in mandatory screening programs that could proactively identify physicians whose ability to deliver safe care may be compromised, before patient harm occurs.[5]

Concerns among medical staff about LCP programs have hindered their widespread implementation. In 2020, Yale New Haven Hospital was sued by the federal Equal Employment Opportunity Commission, which alleged that its LCP program constituted age and disability discrimination.[6,7] Whatever the merits of the claim or its fate in the Trump administration, the suit reflects many physicians' view that LCP policies are unfair, burdensome, unnecessary, and even offensive.

We believe there is a strong case justifying deployment of mandatory LCP programs to promote patient safety. Principles of medical ethics recognize that the interests of patients should be professionals' chief concern. Yet physicians also have interests related to being screened that deserve respect, and LCP programs can and should protect these interests by ensuring procedural fairness. After analyzing LCP policies and interviewing hospital leaders about their perceptions of and experiences with LCP programs,[5] we have developed recommendations for balancing patient safety and physicians' interests.

The Case for LCP Policies

There is social and scientific acceptance that age-related decline in physical and cognitive performance can create a risk of harm to people served by professionals. This recognition has led to policies on mandatory retirement age in other occupations responsible for public safety, such as aviation and law enforcement. Population-level data consistently reveal an age-related decline in overall physician performance spanning clinical specialties, increasing the risk of poorer outcomes among patients cared for by LCPs.[8]

Historically, approaches to ensuring safe practice by LCPs have generally relied on voluntary self-referral or peer reporting, neither of which consistently identifies LCPs whose clinical practice may be problematic.[9] Technical and cognitive slippage may be subtle and difficult for physicians to perceive in themselves. Even in procedural specialties in which errors may be more obvious, supervisors and peers do not regularly observe other physicians' practice and may only hear rumors or reports from nurses, trainees, or other staff, who face hierarchical and personal barriers to reporting concerns.[10,11] Reporting of this type also tends to be reactive, flagging physicians' decline only after adverse events or near misses have occur

Evidence that LCPs can pose ris s to develop mandatory screening programs.[5,12] LCP policies may require testing of the aspects of physicians' cognitive and physical functioning that are relevant to clinical activities; such testing is usually triggered when a physician reaches an age threshold

(commonly 70 years) and is tied to renewal of privileges. Troubling findings from these screening tests typically prompt additional evaluation and consideration of other data on physician performance, with confirmed findings of impairment leading to individualized responses by the hospital. Actions taken may include, where feasible, supportive accommodations enabling physicians to continue their current duties, modifications to their duties, or voluntary or involuntary retirement.

LCP programs have been developed at hospitals and health care organizations, which can evaluate test results and recommendations in the context of each physician's practice and all the other data they have on performance. Hospitals and health care organizations are the settings where any necessary accommodations would be provided, such as a change in the clinical schedule or a shift to administrative or teaching responsibilities. LCPs in independent outpatient practice (without hospital privileges) may not be subject to such oversight, but health care organizations employ a growing majority of U.S. physicians and have specific ethical and professional obligations to ensure provision of safe care.[5]

Yet however persuasive the case for mandatory LCP screening may be, these programs have important implications for physicians' interests. Even if screening itself need not be intrusive, its consequences may be. Among physicians' objections are that tests have imperfect predictive accuracy and that erroneous results could threaten their reputation and livelihood. To be clear, patient safety is paramount, and health care organizations' strong ethical obligation to maintain high clinical standards supports screening LCPs. However, physicians' interests also carry moral weight, and the ethical justification for adopting LCP screening policies does not lessen the imperative to ensure that their design is fair to physicians. Our research suggests that many existing LCP programs overlook key elements of procedural fairness.[5]

Ensuring Fairness to Physicians

Procedural justice is a core ethical consideration for any process that could limit people's interests (their ability to pursue their own preferences or benefits). Procedural justice has both intrinsic and instrumental value. The instrumental aspect lies in the fact that the general perception that a regulatory scheme is procedurally fair helps to establish its legitimacy: the people subjected to the process believe it reflects their views about right and wrong and that whoever is operating it has moral and legal authority to do so.[13] A sense of legitimacy, in turn, strengthens people's willingness to accept and comply with the process and its outcomes.[13-15]

Among the key conceptual pillars of procedural fairness are opportunities to express one's views (have a voice), procedural protections, and minimizing of burdens on the people affected by the process.[16,17] In simple terms, people want to have a chance to give input before decisions are made, to have procedural safeguards against both arbitrariness and the wrongful imposition of restrictions, and to have a sense that any burdens are necessary for achieving an important objective.

When we interviewed 21 medical leaders responsible for LCP policy implementation at U.S. health care organizations, we found that addressing resistance from physicians was among the chief challenges they encountered. Physicians' concerns centered on the appropriateness of the selected age threshold and screening tests and the necessity of mandatory screening.[5] These are fundamentally concerns about fairness, invoking the concepts of arbitrary procedures and undue burden. Other research has also identified fairness as critically important to stakeholders of LCP programs.[18]

Furthermore, our analysis of 29 organizations' LCP policies found that policies rarely described procedural protections for physicians.[5] Less than a quarter of them described a substantive standard for restricting physicians' privileges, an evidentiary standard, an appeals process, or a right to legal representation. Some of these procedural protections may be present in medical staff bylaws regarding the overall process for taking adverse actions affecting physicians' privileges.[19] But physicians are probably unfamiliar with these protections, and it is often unclear how they apply to the LCP screening process.

When commenting on the fairness of their LCP policies, medical leaders at these organizations generally spoke about their policy's evenhandedness (i.e., the fact that all physicians were subject to it), rather than procedural protections.[5] On the other hand, they reported assiduous efforts to be transparent and consult with physicians as they designed their programs (providing opportunities for input) and efforts to minimize logistical hurdles (burden) for physicians undergoing screening.

A more robust set of procedural s… …udicially recognized elements of procedural due process in civil proceedings, would include several components not usually present in LCP policies. Though some of these elements, too, may appear in overall medical staff bylaws, they are also relevant to the LCP

assessment process. *Notice* provisions should ensure both that physicians receive clear communication about what testing will occur and why and that they be fully and compassionately informed of test results. *Fair assessment* requires that the screening tests and processes employed provide an accurate, impartial assessment of relevant skills. An *appeals process* should be developed that gives physicians a meaningful opportunity to contest any restrictions on their privileges based on test results. Physicians who participate in LCP programs, like employees in other industries, retain recourse to the Equal Employment Opportunity Commission and the courts to contest wrongful termination, age discrimination, and disability discrimination.

LCP policies can also more fully communicate a commitment to minimizing burdens on physicians. Minimizing practical and financial burdens of testing is important, but so are two other principles central to public health ethics. In determining whether a legal requirement burdens people excessively, courts consider its *tailoring*, or optimal targeting of the appropriate people; it should neither sweep in some people without good reason nor exclude people irrationally. Is the LCP age threshold, for example, defensible? Should all clinical specialties be required to undergo screening (or the same screening)? Why were alternative approaches such as voluntary self-referral to screening or relying on reports by colleagues rejected? The LCP policies we reviewed typically contained some information about the program's rationale, but many did not make a detailed case for decisions about its scope.[5]

The other key component considered by courts evaluating individual burden is known as *least infringement*. In the context of LCP programs, such an inquiry would center on whether an adverse action taken on the basis of test results is the least-restrictive option that is commensurate with the goal of protecting patient safety. For instance, were accommodations such as a shift in responsibilities considered in lieu of curtailing clinical privileges? The medical leaders we interviewed seemed to aspire to offer LCPs accommodations so that they could continue practicing, but few could cite any actual examples.[5]

What might account for suboptimal procedural protections in current policies? One possibility is that institutional leaders worry that expanding and being more explicit about procedural safeguards could inject an adversarial tone into a process they wish to keep collegial. But our research suggests that many physicians already view LCP screening as threatening and noncollegial. Providing procedural fairness actually builds trust and promotes harmony by increasing acceptance of adverse determinations. Another possibility is that leaders may value preserving flexibility in responding to individual circumstances and worry that emphasizing fairness could prompt complaints that seemingly similar cases were treated differently. But leaders whose lodestar is least infringement should not have difficulty explaining why particular actions are fair and not idiosyncratic, because they will have examined the necessity for those actions before taking them and established consistency with prior similar cases.

Recommendations for LCP Programs

We have several recommendations for balancing patient safety with fairness to physicians in LCP programs (Table 1). First, in constructing and launching an LCP program, leaders should engage physicians early and often, explaining clearly why mandatory screening is necessary to ensure patient safety. This engagement should incorporate meaningful opportunities for physicians to provide input on key design features, such as the frequency, type, and location of screening procedures and the steps to be taken in response to worrisome results. If program leaders subsequently make decisions about program design that do not follow physicians' suggestions, they should make an extra effort to clearly explain the rationale. This deliberative process of justification, construction, and rollout is necessary (if insufficient) for the program to be accepted by the physician community.[5,20]

Second, in terms of the physician population targeted, our empirical work suggests that stakeholders' conception of fairness in LCP programs requires universality, rather than inclusion of only high-risk or procedural specialties. There is inherent arbitrariness in the choice of an age threshold because the timing of decline varies widely. However, a reasonable interpretation of the available literature on physician performance is that screening should begin around 70 years of age, a common threshold in existing LCP programs. Aggregation of data from multiple institutions would facilitate tracking of metrics that could either validate or inform changes to thi

Third, screening procedures sho
safe clinical practice. Test instruments should have good predictive accuracy, use normative data from physicians with good performance and

TABLE 1

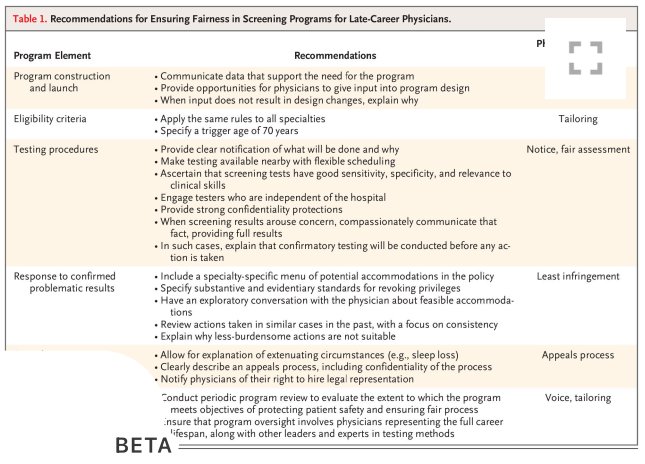

Table 1. Recommendations for Ensuring Fairness in Screening Programs for Late-Career Physicians.

Program Element	Recommendations	Pl
Program construction and launch	• Communicate data that support the need for the program • Provide opportunities for physicians to give input into program design • When input does not result in design changes, explain why	
Eligibility criteria	• Apply the same rules to all specialties • Specify a trigger age of 70 years	Tailoring
Testing procedures	• Provide clear notification of what will be done and why • Make testing available nearby with flexible scheduling • Ascertain that screening tests have good sensitivity, specificity, and relevance to clinical skills • Engage testers who are independent of the hospital • Provide strong confidentiality protections • When screening results arouse concern, compassionately communicate that fact, providing full results • In such cases, explain that confirmatory testing will be conducted before any action is taken	Notice, fair assessment
Response to confirmed problematic results	• Include a specialty-specific menu of potential accommodations in the policy • Specify substantive and evidentiary standards for revoking privileges • Have an exploratory conversation with the physician about feasible accommodations • Review actions taken in similar cases in the past, with a focus on consistency • Explain why less-burdensome actions are not suitable	Least infringement
	• Allow for explanation of extenuating circumstances (e.g., sleep loss) • Clearly describe an appeals process, including confidentiality of the process • Notify physicians of their right to hire legal representation	Appeals process
	Conduct periodic program review to evaluate the extent to which the program meets objectives of protecting patient safety and ensuring fair process Ensure that program oversight involves physicians representing the full career lifespan, along with other leaders and experts in testing methods	Voice, tailoring

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Recommendations for Ensuring Fairness in Screening Programs for Late-Career Physicians.

health (rather than age-based norms from a general population), be validated under similar circumstances, and be resistant to "gaming." Program leaders should give physicians clear notice of which tests will be performed and what they measure, without enabling them to evade accurate assessment by doing preparatory work. Physicians should receive their results confidentially, ideally with opportunities to review findings with an expert who can explain nuances, identify areas of strength, and propose improvement strategies.[21,22] Considerations of privacy, expertise, and consistency argue for independent testing, which might be facilitated by an external vendor or facility.

Fourth, fair notice requires that LCP programs be transparent about how cases of positive (i.e., worrisome) screening results will progress toward confirmatory testing and how medical leadership will evaluate confirmed positive results. There is some tension between giving leaders discretion in these evaluations and ensuring consistency. According to our empirical work, nearly all existing LCP programs permit substantial flexibility and case-by-case decision making about responses to results that arouse concern. Such flexibility lets leaders account for unusual circumstances and develop personalized accommodations to enable physicians to keep practicing under safety-enhancing conditions, advancing the goal of least infringement.

The appearance of arbitrariness may be mitigated by reviewing actions taken in similar cases to assess consistency, by including a menu of potential accommodations in LCP policies, and by explaining to affected physicians why certain accommodations were deemed inappropriate. Examples of accommodations include minimizing night shifts, replacing clinical work with teaching or other activities, voluntarily reducing scope of privileges, restricting practice to caring for lower-risk patients, scheduling longer appointments with patients, reducing volume of appointments or procedures, and enhancing peer support.[23-25]

Fifth, the inherent uncertainty and potential for subjectivity in LCP testing and the potentially serious effect on physicians' livelihood argue for providing an appeals process, during which confidentiality must be maintained. This pathway should allow affected physicians to suggest accommodations or other solutions[21] or argue for retesting or additional testing. Although ideally the process would be nonadversarial, physicians should be made aware of their right to legal representation.

Finally, LCP programs should be developed and deployed with humility, guided by the principle of continuous improvement. Care should be taken not to mistakenly hold LCPs to a higher standard than younger physicians simply by applying greater scrutiny to their practice.[26] Programs should be subjected to periodic formal evaluation to assess whether they are curtailing unsafe care and respecting physicians' interests. Relevant metrics include the proportion of eligible physicians actually screened (including a record of any physicians who voluntarily retired rather than undergoing screening); the number of positive screening results and confirmed-positive results and the ages of the physicians in question; specialty-specific data on actions taken in response to troubling results; the number and outcomes of appeals; and tabulations of adverse events among patients cared for by physicians 70 years of age or older. Data should also be collected on the opinions and experiences of physicians of all ages, including data permitting assessment of whether LCP programs pose inequitable burdens on physicians or have disproportionate downstream effects on specific patient groups.

Our recommendations for promoting procedural fairness in LCP programs seek a pragmatic balance, aiming to inform meaningful improvement without appearing so burdensome that organizations dismiss them as unrealistic. The data on LCP-program performance described above will provide important insights into whether institution-based LCP programs are protecting patient safety while respecting the interests of physicians. In addition, state medical boards could play an important oversight role, independent of potential corporate considerations that may factor into LCP design and implementation, and provide additional assurances to physicians regarding procedural fairness as well as avenues for complaints. Relatedly, states with strong and well-established physician health programs may be able to provide initial testing, or follow-up or confirmatory testing, in partnership with health care organizations.

Ultimately, the aging physician workforce requires compassionate, purposeful, and principled policies that respect their rights while safeguarding patients. When LCP-program designs include procedural protections and reflect evidence about when age-related decline occurs and how it can be detected and addressed, LCPs can be treated differently from younger physicians, to promote patient safety, without being treated unfairly.

NOTES

Disclosure forms provided by the authors are available at NEJM.org.

SUPPLEMENTARY MATERIAL

Disclosure Forms (nejmms2510494_disclosures.pdf)

DOWNLOAD 524.00 KB

REFERENCES

1. Dellinger EP, Pellegrini CA, Gallagher TH. The aging physician and the medical profession: a review. *JAMA Surg* 2017;152:967-971.

   Go to Citation Crossref PubMed Web of Science Google Scholar

2. GlobalData. The complexities of physician supply and demand: projections from 2021 to 2036. Washington, DC: AAMC, 2024 (https://www.aamc.org/media/75236/download?attachment).

   Go to Citation Google Scholar

3. Garrett KD, Perry W, Williams B, Korinek L, Bazzo DEJ. Cognitive screening tools for late career physicians: a critical review. *J Geriatr Psychiatry Neurol* 2021;34:171-180.

   Go to Citation Crossref PubMed Web of Science Google Scholar

4. Gaudet CE, Del Bene VA. Neuropsychological assessment of the aging physician: a review & commentary. *J Geriatr Psychiatry Neurol* 2022;35:271-279.

   Go to Citation Crossref PubMed Web of Science Google Scholar

5. White AA, Gallagher TH, Osinska PH, Kramer DB, Garrett KD, Mello MM. Ensuring safe practice by late career physicians: institutional policies and implementation experiences. *Ann Intern Med* 2024;177:1702-1710.

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