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Age-Triggered Cognitive Testing of Late-career Physicians: Time to Reassess Current Practices

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ABSTRACT

Physicians and health care organizations have been urged to respond to public concerns regarding age-associated cognitive impairment among physicians while avoiding ageist stigma and preserving due process. Because cognitive aging is heterogeneous, many clinicians retain or deepen clinically relevant capacities while others develop cognitive, medical, or sensory impairments that raise justifiable safety concerns. A key ethical and evidentiary paradox confounds discussions regarding current assessment policies: low scores on a focused cognitive assessment are found in many impaired physicians but are not in themselves evidence of clinically meaningful performance errors. This paper reframes age-triggered cognitive testing as a form of "pre-emptive justice," in which presumptive risk indicators are treated as evidence of high probability for wrongdoing. The authors argue for a more defensible approach grounded in validated indicators of job performance, matching evaluations with role duties and expectations, and taking into account the possibility of work accommodations. We review usual and pathological cognitive aging, summarize evidence on aging and physician performance, compare current assessment models, homegrown and outsourced, and highlight quality assurance programs in Canadian provinces that monitor physicians through their entire career trajectories. We conclude with a proposal for stepwise whole-career quality assurance program that evaluates practice-linked performance

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data at all career stages while reserving a more intensive targeted health and cognitive evaluation for those physicians whose data suggest higher risk. (Am J Geriatr Psychiatry 2026; 34:1215−1221)

Editorial accompaniment, please see page 1222.

Highlights

- **What is the primary issue addressed by this study?**
  The authors examine the use of cognitive screening and neuropsychological evaluation in assessing the effects of cognitive aging on late career physicians (LCP) by reviewing the empirical, ethical, and policy limitations of current age-triggered cognitive assessment programs.
- **What is the main finding of this article?**
  Although cognitive aging may affect some domains relevant to clinical work, the relationship between cognitive test performance and actual physician performance remains insufficiently validated. The authors argue that policies targeting LCPs for cognitive testing may represent a form of preemptive justice, in which age-associated cognitive metrics are used as a surrogate for presumed performance deficits rather than evidence of actual impairment or unsafe practice.
- **What is the meaning of this finding?**
  To protect patients while treating physicians fairly, health systems should adopt career-long, impartial, evidence-based, prospectively validated quality-assurance approaches tied to validated risk indicators and actual clinical performance, reserving cognitive evaluation for circumstances in which specific concerns justify further assessment.

INTRODUCTION

Wellness and credentialing committees hear concerns about aging clinicians regarding clinical errors such as dangerous prescribing, inappropriate interpersonal behavior, slowed procedural performance, and documentation deficiencies.[1] These concerns can trigger credentialing or privileging restrictions that can result in major career consequences for physicians, patients, and employers. Late-career physician (LCP) policies have emerged to protect the public from presumed risk but they remain controversial because they treat advanced age as a validated proxy for impairment and because the evidence linking cognitive screening results to real world job performance remains incomplete. The challenge is to create a system that 1) identifies meaningful risk early enough to prevent or limit harm to patients, 2) respects physician rights and due process, 3) avoids age-based discrimination, 4) uses tools with evidence-based validity for high-functioning professionals, and 5) provides fair and supportive pathways for remediation, accommodation, or role transition. After reviewing usual and pathological cognitive aging, describing their relationship to physician performance, and considering current age-triggered cognitive assessment approaches, we will suggest an assessment approach which incorporates these characteristics.

USUAL COGNITIVE AGING

Usual aging is associated with variable changes across multiple cognitive domains. In general, crystallized intelligence, which relies on accumulated knowledge, is relatively preserved. Fluid intelligence, the capacity to address novel challenges that may require new information and new approaches, draws on executive functions such as processing speed, complex attention, and working memory and is vulnerable to the effects of aging.[2,3] Some evidence suggests that compensatory neural recruitment maintains performance despite mild impairment when cognitive load is not excessive; however, performance may

degrade under greater demand, multitasking, unfamiliar tasks, or time pressure.[4]

Clinical work requires complex and often rapid decision-making involving multiple domains of cognition. Complex attention, processing speed, and working memory are engaged in order to process visual and auditory input from multiple sources including patients, collateral informants, other providers, and electronic medical records, often simultaneously utilizing divided and sustained attention, maintaining a focus on critical information. Short- and long-term memory are employed in retaining patient information and integrating new data as available with preexisting knowledge to provide evidence-based care. Executive function is actively involved in abstracting and synthesizing multiple types of clinical information and setting aside irrelevant information, avoiding impulsive action, understanding when a clinical decision presents novel challenges, anticipating clinical outcomes, and conforming to the requirements of a regulatory environment. Intact social cognition is required in order to sustain a theory of mind and empathy, to recognize one's own and others' emotions, and to maintain a professional interaction with staff and patients. These cognitive skills are essential for all physicians and particularly for the more cognitively intense fields of psychiatry, internal medicine, and medical specialties. Other cognitive faculties such as manual dexterity, perceptual-motor function, and vision take on special value in the performance of surgical procedures. Vision and pattern recognition are critical in the work of radiologists, pathologists, and dermatologists.

Even usual cognitive aging can affect the quality of patient care. In clinical environments, usual cognitive aging may impair the functions described above. Physicians with minor cognitive changes may demonstrate increased reliance on familiar pattern recognition and decreased flexibility in responding to stresses such as conflicting or incomplete evidence, demands of new technology, or pressured workflows requiring rapid decision making. Sensory decline (vision/hearing), sleep disruption, and the consequences of medical comorbidity can amplify the effect of mild cognitive inefficiencies, particularly in high-demand settings.[5] On the other hand, it is worth noting that physicians as a group possess higher baseline cognitive functioning in areas such as language, semantic memory, and judgment that may compensate for age-related changes and preserve the effectiveness of an aging physician.

PATHOLOGICAL AGING

The number of physicians suffering from actual neurocognitive disorders is unknown but their high frequency in the general population suggests a prevalence that is not trivial. The mildest of neurocognitive disorders is Subjective Cognitive Decline (SCD), not included in DSM-5-TR, in which a sense of suboptimal performance is experienced despite apparently normal functioning and unremarkable scores on brief cognitive screening instruments. SCD is associated with subtle functional changes, however, and with a longer term risk of significant cognitive decline.[6] Mild Neurocognitive Disorder, formerly known as mild cognitive impairment, denotes the presence of measurable decline despite preserved independence supported by compensatory strategies and often concealed by cognitive reserve.[7] Physicians, like other highly educated individuals, possess significant experience-based compensatory skills which in some cases can offset overt manifestation of functional decline and conceal impairment.[5] On the other hand, significant cognitive decline is likely to introduce significant risks into clinical encounters.[5,8]

PHYSICIAN AGE AND PERFORMANCE

Studies have demonstrated a decline in cognitive functioning of older physicians detectable at about 60 years, which is 10 years later than in the general population.[9] Physicians' extensive education and cognitively demanding occupational experience may contribute to cognitive reserve, as conceptualized by Stern and colleagues.[10] Aging, however, is recognized to affect physicians' performance in a variety of ways. An often-cited systematic review reported that a substantial proportion of studies found decreasing adherence to standards of care with increasing years in practice, though results varied by setting and measure.[11] Outcomes research in surgical disciplines shows some heterogeneity; some investigators have found increased risk for certain outcomes among older surgeons in some contexts,[12] while others show neutral associations or emphasize the moderating

role of procedure volume, team structures, and practice environment.[13] Advanced age is relevant but it is also not an unequivocal proxy for more meaningful determinants of cognitive aging and professional performance such as training and certification, continuing education, current mental and physical health, medications, sensory function, workload and practice environment, poor professional or social supports, and objective performance expectations.[5,8,14]

CURRENT LCP ASSESSMENT MODELS AND THEIR LIMITED ACCEPTANCE

Contemporary LCP assessment protocols fall generally into two categories: those run internally ("homegrown" protocols), and outsourced evaluations performed by specialized assessment centers.[15,16] The homegrown programs vary widely in included elements and evaluation tools Although more convenient and less costly, such programs may be vulnerable to inconsistent implementation, less specialized expertise in test selection/interpretation for high-performing individuals, and conflicts of interest. The assessment centers typically provide a more extensive and comprehensive approach that is standardized and may be perceived as more objective, while sometimes introducing greater cost, access barriers, and potential loss of local control. Some health care systems rely on a hybrid approach. Many assessment programs draw upon the influential work of the California Public Protection & Physician Health (CPPPH) organization, which published a physician assessment guideline proposing the following assessment components: history/physical (including sensory/neurologic review), performance data and chart review, and cognitive evaluation, with confidentiality and process recommendations.[8]

A well-publicized homegrown program at Yale New Haven Hospitals incorporated an age-triggered assessment process for clinicians aged 70 and older, including the CPPPH elements. The Equal Employment Opportunity Commission (EEOC) sued, claiming violation of the ADA and ADEAR acts.[17] Cognitive assessment was dropped from a similar program at the Scripps Institute after an out of court settlement.[18] The Stanford Late Career Practitioner Policy, implemented in 2012, was compelled to drop cognitive assessment from its age-triggered clinician review policy after this form of evaluation was rejected by a faculty senate vote.[19,20] While healthcare institutions have argued that age is a "bona fide occupational requirement" and a proxy for cognitive impairment, that claim has not proven defensible because the bona fide occupational requirement justification criteria have not been convincingly met.[21]

Outsourced evaluations include comprehensive competence and "fitness for duty" assessments that incorporate neuropsychological testing, structured chart review, standardized patient encounters, simulations, and targeted remediation plans. The UC San Diego Physician Assessment and Clinical Education (PACE) Program is frequently cited as a major U.S. assessment/remediation center offering both late-career screening and tailored competence evaluations across specialties.[22,23] These physician evaluation centers have been influential in policy-making and have contributed data demonstrating that physicians referred "for cause" are likely to reveal cognitive testing performance deficits; however, no program has effectively established a link between cognitive performance deficits in a physician not known a priori to lack competence and performance deficits in practice.[9]

IS MANDATORY AGE-TRIGGERED PREINFRACTION COGNITIVE TESTING A FORM OF PRE-EMPTIVE JUSTICE?

A central ethical issue is whether a cognitive assessment, which in some LCP policies is brief and focused, is a valid indicator of actual clinical performance deficiencies. Justifying restrictions of professional credentialing or privileging on the basis of such an assessment evokes the dystopian justice system portrayed in Philip K. Dick's famed short story, Minority Report, in which preinfraction limitations of freedom were justified by psychics' predictions of risk rather than actual evidence of criminal activity.[24] In the context of LCP performance, age-triggered cognitive assessment initiates a system of pre-emptive or preventive justice: an intervention that can only be justified if the prediction is valid, the downstream consequences are proportionate, and the process includes robust safeguards.

In Dick's world and in our health care system, those conditions are lacking. Risk assessment fields

outside of medicine have highlighted the shortcomings and pitfalls of acting on predicted risk.[25,26] Screening for events which are rare is complicated by the higher frequency of false positives. Older physicians with cognitive deficits which affect performance may represent only a fraction of those who demonstrate detectable cognitive deficiencies on in depth testing. Because the prevalence and nature of clinically meaningful impairment among actively practicing clinicians is not well established and because many cognitive screening tools were not designed or normed for high-performing professionals, age-triggered cognitive assessment policies potentially succumb to a fallacy by accepting the assumption that a tool which identifies cognitive differences can reliably assign a true risk for unsafe performance. Cognitive testing is only one element of assessment, but correlation of an isolated low cognitive test score with presumed unsafe practices risks unjustified restriction, reputational harm, and legal exposure—especially when used as a barrier to credentialing and recredentialing.[9]

WHOLE-CAREER QUALITY ASSURANCE AND CAREER SUPPORT

Some Canadian physician quality assurance programs provide a different approach to reducing the risk to patients imposed by impaired physicians at any age or career stage. Canada does not have a uniform national approach to quality assurance. Assessment programs are province-specific and administered by Colleges of Medicine rather than individual clinics or hospitals, offering a wider coverage of physicians by including those not employed by an institution. The Canadian Medical Protective Association notes that some provincial Colleges monitor and assess physicians beyond a specified age through formal assessments and quality assurance programs, but approaches vary.[14] A key policy feature relevant to U.S. assessment discussions is the use of broader, career-long competence expectations that are not limited to later life.

Two Canadian provinces explicitly incorporate age-triggered assessment. Ontario's Quality Assurance Program includes mandatory participation beginning at age 70 with individualized reassessment every 5 years. An optional quality improvement track resembles the US's CME-based approach.[27,28] Quebec's professional inspection framework includes focused evaluations beginning at age 60 with a questionnaire that assesses risk factors and can lead to circumscribed feedback or more in-depth evaluation when indicated.[14]

The College of Physicians & Surgeons of Alberta's Continuing Competence/Physician Practice Improvement Program (PPIP) is structured as a multi-year cycle of recurring assessments requiring participation by regulated members and emphasizing practice-driven and standards-based quality improvement activities across the career span. Age is not a trigger but is considered in the evaluation process.[29,30]

Nova Scotia's evaluation program, by contrast, is age-neutral, emphasizing workplace-based assessment and evaluating performance in the physician's actual clinical setting through multiple programs overseen by the provincial College.[31,32]

Taken together, Canadian systems illustrate an alternative framing: 1) competence monitoring is a normal expectation across the lifespan rather than a late-career concern although age is taken into account; 2) assessment is integrated into quality improvement structures rather than administered by health care institutions or specialized businesses; and 3) escalation to intensive evaluation can be tied to practice context, risk flags, or workplace-based observation rather than proactive neuropsychological or physical screening.

A PROPOSAL FOR WHOLE-CAREER ASSESSMENT AND SUPPORT

Building on the above, a pragmatic, ethically defensible approach requires a shift from age-triggered cognitive or other screening to a whole-career framework that begins with measures tightly linked to practice context and escalated only as needed. A model system might include the following elements:

- Stage 1 (universal, career-long): Leverage existing quality/safety systems (OPPE/FPPE, peer review, chart audits, morbidity/mortality review, patient complaints, 360-degree feedback) with explicit, specialty-calibrated thresholds for escalation. Offer confidential wellbeing support, sensory evaluation, or assistance with other health

conditions to all clinicians at routine intervals (or on request), with clear routes to accommodations and workload modification. Holistic assessment at specified intervals is mandatory throughout the physician's career whether employed by an institution or practicing independently and whether or not board certified.

- Stage 2 (triggered, practice-linked): When practice flags emerge, start with a targeted chart review, focused peer review and structured practice-environment interviews before cognitive or physical testing.
- Stage 3 (selective in-depth testing): Use medical or neurocognitive testing only when indicated by functional concern or corroborated performance signals; ensure clinician-appropriate norms, transparent thresholds, and explicit attention to the risk of false positives.
- Due process: Build transparent governance; include notice, right to respond/appeal, right to counsel, and proportional remediation-first responses.
- Transitions: Provide structured, dignified late-career transitions (reduced call, narrower scope, increase in supervision/teaching roles, access to dictation software or scribes) without coercive retirement.

LIMITATIONS

This manuscript focuses on the validity and ethics of cognitive testing of late career physicians as currently implemented in many "Late Career Physician" policies. The authors recognize that cognitive testing, whether or not valid and ethical, is only one component of current Late Career Physician Policies. In practice, neuropsychological test results are tempered by other data available to a Department Chair or Credentialing Committee.

The authors acknowledge that many institutions attempt to identify impaired physicians through OPPE programs which include some combination of periodic documentation review, performance data review, and peer comments. These programs are to be commended for their lack of age-based bias. We do not intend to discount their value; however, they rarely identify subtle impairments and they do not cover the many physicians who are not institutionally affiliated.

Neither do we intend to overlook the important quality assurance programs in place in many hospitals whose staff are periodically assessed via OPPE and, where appropriate, focused performance evaluation (FPPE), followed by in-depth testing where indicated. While these programs serve an important purpose, our focus here is to point out the limitations of cognitive testing that is not "for cause" but rather age-triggered, and to argue in favor of a new model which is uniform, career-long, holistic in its assessment of physicians' skills as related to their roles, and linked to professional guidance when performance deficits are identified.

CONCLUSION

While our focus has been on cognitive testing, we believe any age-triggered physician assessment may appear protective while conferring limited benefit to the public and risking harm to the physicians evaluated. The fallacious application of a pre-emptive justice approach is potentially dangerous unless predictive validity and safeguards are strong. A whole-career strategy grounded in practice-linked evidence, stepwise escalation, and procedural fairness better protects patient safety, clinician dignity, and legal risk management. Canadian provincial programs illustrate how career-long competence and quality systems can normalize assessment across the professional lifespan and reduce the need for blunt age triggers.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the authors used ChatGPT for reference search assistance and grammatical checking. The authors reviewed and edited the output as needed and take full responsibility for the content of the published article.

AUTHOR CONTRIBUTIONS

J.E. conceived the framework of this manuscript and prepared the initial draft. All authors participated in the literature search, made substantial intellectual contributions to the work, and approved the final manuscript.

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