American Society of Anesthesiologists®

1501 M Street, N.W. • Suite 300 • Washington, D.C. 20005 • (202) 289-2222 • Fax: (202) 371-0384 • www.asahq.org

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When Age is No Longer Just a Number

A common, but seldom spoken matter is becoming more significant in anesthesiology—aging. Just as the rest of us age, physicians do as well. Due to the growing number of older physicians in practice, there have been increased discussions in the health care community about physician capability and the maintenance of skills in older age (Moutier, Bazzo, & Norcross, 2011). Although there is no mandatory retirement based upon age for anesthesiologists, there is a question of whether it should be considered as a risk factor that merits assessment for adequate functioning. The fact of the matter is everyone ages differently. Among topics of growing interest to account for the changing environment in physician practices is the implementation of an age-based screening to detect the decline in cognitive skills and competence evaluation (Moutier, Bazzo, & Norcross, 2011).

Practices vary in the way they assess and schedule the older physician to accommodate both the needs of the practice and the physician. For example, some practices allow (or may require) the older physician to stop taking call at a certain age. Nevertheless, the field of medicine holds itself to high principles of care and proficiency, the first tenet being *primum non nocere*, "First do no harm" (Moutier, Bazzo, & Norcross, 2011). This means practices are aiming to insure safe methods of medical care for both patients and physicians; aiming to decrease the risk for medical error. Given these standards, the aging anesthesiologist will be affected whether routine assessments are implemented, or, recognized impairments lead to an abrupt retirement.

The AMA Physician Masterfile data demonstrates a growth in aging physician population, with a 2.3 percent growth in active physicians age 65 or older between 1985 and 2005 (AMA, 2011). Although it seems like a small increase, it is a rising concern for anesthesiologists. Often, policies for addressing potential health or age-related deficiencies in the field of medicine occur on a case-by-case basis (Moutier, Bazzo, & Norcross, 2011). This method of self-regulation can appear less stressful short-term but is of more significance long-term. Recently, an anesthesia group in Washington, DC was faced with the difficult situation of having one of their longstanding anesthesiologists precipitously driven into retirement as a result of his inabilities to safely perform his duties. This situation could potentially affect any group and practicing anesthesiologists.

Although clinical ability improves with experience, neuropsychological assessment and clinical trials portray that certain abilities are impacted with age. Older physicians may pose a higher patient risk when involved in complex patient situations, performing certain major operations, and multitasking. Nevertheless, mandatory retirement should not be established for physicians based merely on age. This in itself poses as a risk factor for incompetence (Moutier, Bazzo, & Norcross, 2011).

Bulleted below are collective data gathered at the November 2011 Coalition for Physician Enhancement (CPE) and the University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program Conference regarding aging and physician performance (Moutier, Bazzo, & Norcross, 2011).

- Aging results in a wide spectrum of physiological changes which *may* affect clinical competence. Amongst the most important are the reductions in dexterity and visual-spatial acuity, short-term memory, problem-solving, and ability to adopt new ideas and to re-examine old ideas.
- Aging is but one of several risk factors which may impact clinical competence: The degree and rate of decrement caused by aging do not occur in a linear fashion and the impact upon the clinical competence and performance of any one physician is highly variable.
- Programs exist which can and do assess medical knowledge, historical aspects of patient care and simulations of patient care and interpersonal skills and communication, but generally these assessments take place after the occurrence of an untoward outcome. Physicians are not regularly and routinely assessed.
- Assessment could include evaluation of mental and physical health, review of actual performance of clinical care — either diagnostic or procedural, documentation that learning and behavior change as a result of participation in CME has taken place, and review of quality improvement efforts.
- We should not establish mandatory retirement for physicians based on age alone for many reasons, including the inability to definitively conclude that age, in and of itself, is a risk factor for incompetence or dyscompetence. Establishing mandatory retirement based on age alone would further negatively impact the physician shortage in the United States and would lead to the loss of the wisdom and experience of many capable physicians.

In evaluating cognitive function, practices need to identify how to approach the matter of the aging anesthesiologist. The May 2010 issue of the ***ASA NEWSLETTER*** includes an article titled *The Aging Partner: What to do About Compensation, No Call and When the Doctor Does Not Want to Cut Back* (Scott, 2010). In this article, Ms. Scott discusses ways practices may establish a structured plan so that groups can devise guidelines to accommodate both group and individual needs. It addresses important issues pertaining to implementing such a structure.

Readers will also be interested in an article by Orkin et al from the November 2012 edition of Anesthesiology, United States Anesthesiologists over 50, Retirement Decision Making and Workforce Implications (http://journals.lww.com/anesthesiology/fulltext/2012/11000/united_states_anesthesiologists_over_50_.14.aspx)

In conclusion, both groups and individual anesthesiologists need to be proactive in addressing this issue in a manner that is beneficial for patients, practices, and physicians. Age-based screening for competency is an important safety mechanism in the profession of medicine. The implementation of a defined model will allow anesthesiologists to manage their retirement plan in an appropriate manner for both themselves as well as their practice.

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