www.medscape.com

Clinicians Are Talking About Aging Surgeons

Gordon H. Sun, MD, MS | July 21, 2014

Time to Throw in the Scalpel?

Medscape recently posted "How Should I Report an 'Aging' Surgeon?" in which an operating room (OR) nurse requested advice on how to address a delicate state of affairs in her workplace. A 75-year-old surgeon's clinical skills were perceived to be declining, potentially leading to suboptimal care and compromised safety.

This is an incredibly sensitive, emotionally charged situation, as a myriad of disparate factors come into play: surgeon autonomy and dignity, the working dynamic between physicians and nurses, patient care quality and safety, evolving standards of care, the aging workforce, and more.

Carolyn Buppert, a healthcare attorney (and nurse practitioner) writing for Medscape, replied that the nurse could first discuss these observations directly with the surgeon in a gentle, nonconfrontational manner backed by specific examples, and consider getting a peer (another surgeon or anesthesia provider) to observe and pass judgment. The OR nurse was also advised to communicate with nursing administrators or the head of surgery. Lastly, the nurse was advised to avoid going to the state medical board until all possible internal mechanisms had been exhausted; otherwise, the nurse could be placed in a no-win situation if no one else at the hospital can corroborate the nurse's observations. The OR nurse was informed that by discussing concerns with the surgeon in question and with other authorities, the nurse was acting appropriately as the patient's advocate.

Perhaps not surprisingly, the article generated a substantial amount of commentary from Medscape readers, much of which exposed starkly differing viewpoints on this complex situation. From the 250 comments posted online, we have extracted 6 themes that we hope will be informative for anyone in healthcare facing a similar situation. *[Editor's note: Some reader comments have been edited for clarity.]*

Current Trends on Elderly Surgeons in Clinical Practice

Carolyn Buppert's comment on the aging of physician and nurse "baby boomer" populations is borne out by epidemiologic data in the United States. The Association of American Medical Colleges (AAMC) reported that in 2010, more than 40% of the nearly 800,000 actively practicing physicians in the United States were at least 55 years old, a nearly 3% increase from 2007. Within most surgical specialties, the percentage of providers at least 55 years old was above the 40% national mean. Highest among surgical specialties in the proportion of practitioners older than 55 years were thoracic surgery (51.6%), orthopedic surgery (49.7%), and urology (49.3%).[1]

Peter Carmel, a pediatric neurosurgeon and past President of the American Medical Association (AMA), commented that about 20% of US physicians were older than 65 years.[2] On the basis of 2009 AMA Masterfile data, about 8.5% of all active US surgeons were at least 70 years old, including 11.6% of thoracic surgeons.[3] A 2014 paper in the *Annals of Surgery* [4] estimated that the number of active US surgeons older than 70 years of age is as high as 20,000.

Mandatory Age Restrictions: Healthcare and Other Industries

There is no national mandatory retirement age for surgeons and other healthcare providers in the United States. This reflects the current American legal climate; and with rare exceptions, the Age Discrimination in Employment Act of 1967 and subsequent amendments outlaw compulsory retirement on the basis of age.[5] Still, several readers felt that a mandatory age limit for surgeons might be needed, and suggestions ranged from 65 to 75 years. One surgeon jokingly mentioned the so-called "rule of 210": "If the combined age of the surgeon, patient, and anesthetist is greater than 210, the mortality rate is 100%."

Select individual medical staffs and healthcare organizations have voluntarily begun discussing increased screening of older healthcare providers. As of September 1, 2012, Stanford University Medical Center began

requiring medical staff, including physicians and PhD-level practitioners, aged 75 years or older, to undergo physical examination, cognitive screening, and peer assessment of clinical performance every 2 years. The threshold of age 75 was chosen by the Stanford task force that developed the policy because the incidence of Alzheimer disease increases significantly starting at age 75.[6]

The University of Virginia Health System and Driscoll Children's Hospital (Corpus Christi, Texas) require periodic testing for physicians beginning at age 70 years.[7] However, such programs are still rare. According to Jonathan Burroughs, a national healthcare consultant and CEO of the Burroughs Healthcare Consulting Network, Inc., only 5% of the more than 900 US hospitals with which he has consulted have any active policy for screening older providers. "Most high-risk professions in America, such as the aviation industry and military, require a 'fitness for work' assessment for all professionals," Dr. Burroughs said, commenting that it would be reasonable for healthcare to follow suit to address potentially treatable undiagnosed impairments in a more proactive and supportive way.

Little information has been published on recommendations or policies on aging surgeons or other healthcare providers outside of the United States. One physician in India reported that the retirement age there was 65 years; this threshold appears to have been raised recently as a result of staffing shortages in state-run hospitals.[8] In Pakistan, the physician age limit is 70 years; beyond this threshold, physicians are either obligated to retire or continue in a nonclinical setting such as teaching or research.[9] In contrast, a surgeon from Italy wrote that in his country, surgeons who reached 65 years of age were obligated to continue work, rather than retire, in the public healthcare sector unless they voluntarily switched to a private delivery model. In the United Kingdom, the mandatory retirement age of 65, across all professions, was phased out in 2011.[10,11] However, *Pulse*, a UK publication for general practitioners, reported in 2012 that on the basis of the case of *Selsdon vs. Clarkson Wright and Jakes*, medical practices might be able to justify a mandatory retirement age for older physicians if the chosen age was "proportionate" and for a "legitimate aim."[12]

Observers have commented that age restrictions exist outside of medical practice in industries where consumer safety is directly at stake. In 1959, the US Federal Aviation Administration (FAA) instituted the controversial "age 60 rule," in which commercial airline pilots were obligated to retire upon their sixtieth birthday, a policy that was based on research sponsored by the FAA and supported by Congress.[13] In December 2007, the Fair Treatment for Experienced Pilots Act was signed into law, raising the mandatory retirement age to 65 years. This is one of only a few examples in the United States in which a mandatory retirement policy is not considered age discrimination.[14]

Should Age Be the Only Factor?

Many readers argued that age is not the only factor influencing surgeon performance, and that older surgeons have more experience to draw upon than do younger surgeons. An analysis of approximately 460,000 Medicare patients undergoing major surgery in 1998-1999 suggested that for most procedures, surgeon age did not predict operative risk. However, when certain complex procedures such as pancreatectomy, coronary artery bypass grafting, and carotid endarterectomy were performed by surgeons older than 60 years, particularly those with low operative volumes, mortality rates were higher than when the surgeon was aged 41-50 years.[15]

A systematic review of 62 studies examining the relationship between physician age and clinical knowledge or performance found that about half of the studies suggested an association between increasing years in practice and poorer performance. These results may not be attributable to older age per se, but rather to the possibility that older physicians are not consistently updating their body of knowledge to incorporate more modern tools and techniques.[16]

Several readers commented that rather than age, any focus on the surgeon's performance should be concerned with "objective" measures that may or may not be age-related, such as hand tremors. Aging influences many aspects of human biology, such as strength, manual dexterity, visuospatial ability, and cognitive function. However, many of the deleterious effects of aging can be counteracted to a substantial degree in older adults with extended practice.[17]

Results from the American College of Surgeons (ACS)-supported Cognitive Changes and Retirement among Senior Surgeons (CCRASS) survey show that 61% of practicing surgeons aged 60 years or older performed within the range of surgeons aged 45-59 years on 3 subtests of the Cambridge Neuropsychological Test Automated Battery, which tests sustained visual attention, reaction time, and visual learning and memory. Specifically, 78% of surgeons aged 60-64 years and 38% of those aged 70 years and older performed within the range of younger surgeons, and no senior surgeon performed worse than young surgeons on all 3 tasks. The study concluded that older age does not guarantee that cognitive deficiency is present.[18]

Of interest, other readers believe that forcing out surgeons simply on the basis of advanced age does not take into consideration whether older surgeons are equipped to deal with work and life outside of the operating room. A cardiac surgeon who voluntarily stopped operating at age 64 years finds that many surgeons have "not made any plans on what to do in retirement and are fearful of being bored and banished to playing golf," whereas an otolaryngologist feared that retired surgeons might "fall into depression." A 1994 survey of 659 American Surgical Association members found that fewer than half had any retirement plans, including 40% of surgeons older than 70 years who were not yet retired.[19] In 2011, a survey conducted by the physician staffing firm Jackson & Coker found that as a result of the recent economic recession, 52% of 522 physicians postponed their retirement plans.[20] Financial security aside, many readers proposed a wide range of solutions to occupy older surgeons' time after retirement, many of which involve continued participation in medicine: writing, teaching, research, and volunteer work.

One issue not raised by any reader was surgeon workforce sustainability. The 2.6% rate of growth in the number of US surgeons was slower than the 7.8% growth in the number of physicians overall.[3] The ACS has reported that the influx of newer surgeons also has not maintained pace with overall population growth and thus may not be sufficient to replace older surgeons as they retire.[21]

Professional Organization Policy Statements

One reader, an active surgeon in India with 40 years of experience, stated that "the time has come for the World Health Organization or some such body to come up with basic guidelines that will not only protect the patient, but will also save aging surgeons from embarrassment, continue to utilize their expertise, and be morally correct." Unfortunately, to date, formal organizational policies on how to approach the issue of aging surgeons and other healthcare providers are scarce.

Physician impairment, as defined by the Federation of State Medical Boards (FSMB), the Federation of State Physician Health Programs (FSPHP), and the AMA, does include in part "physical illness, including but not limited to deterioration through the aging process, or loss of motor skill."[22,23] However, the FSMB does not include advanced age by itself as a criterion for ineligibility to hold a medical license in the United States.[24] The AMA Senior Physicians Section hosted an educational session on the aging physician at its 2014 annual meeting, where the speakers discussed impairment in older physicians and the potential role that the AMA could play in establishing competency measurements.[25] According to a representative from the AMA, a report on the issue of competency in aging physicians is in development for a future conference.

The ACS guidebook *Being Well and Staying Competent: Challenges for the Surgeon* states that age alone is an inadequate measure for determining the retirement age for surgeons. It recommends that credentialing bodies take an individualized approach to assessing the skills of older surgeons, emphasizing periodic psychomotor assessment, medical evaluation, and peer evaluation. The guidebook suggests that starting ages for testing may range from 62 to 75 years, with 65 being a typical threshold.[26] According to Kevin Garrett, a general surgeon and former ACS Governor from 2007 to 2013, the ACS is currently planning to convene a task force to produce a formal policy statement.

The "Chain of Command" in Reporting Concerns About Aging Surgeons

There are no widely published best-practice guidelines on how to report potential concerns with the performance of aging surgeons or other providers. As such, hospitals and practice groups have had to develop internal

mechanisms, reflected in the wide and often conflicting variety of reader suggestions and personal anecdotes about similar situations.

Two issues are pertinent with respect to the chain of command. Several readers criticized the OR nurse for even bringing the issue up. Readers implied that the nurse was not being respectful ("Any change in [the surgeon's] ability must be dealt with using a higher degree of respect and appreciation") or was unqualified to pass judgment ("From what I've seen, there usually is an assistant/resident next to the surgeon who [in my opinion] is more knowledgeable and who could/should notice mistakes better than a nurse.") The comments we reviewed suggested that regardless of the approach taken by the nurse, there will certainly be opposition, either in terms of the qualifications of the complainant or the methods used to report concerns.

The OR nurse's original inquiry stated that the working relationship with the surgeon has lasted 30 years. Several readers believed that this long and presumably stable relationship represented an adequate foundation upon which the nurse might consider talking with the surgeon directly, either alone or with other colleagues. Despite this, a significant number of other readers were concerned that the surgeon might not be approachable and could "shoot the messenger," allowing internal hospital politics to quickly end the nurse's career. As one nursing administrator commented, "I have never seen this type of confrontation, even if it is well stated, result in a satisfactory solution for the nurse, and it infuriates the physician." Another reader commented, "You can't be an effective patient advocate if you're out of a job."

Many readers wrote about quality assurance protocols and specific personnel who should be approached when concerns about potentially suboptimal care are raised. The phrase "chain of command" recurred throughout readers' comments. As an example, a physician at a tertiary care center stated that at his hospital, the sequence of individuals to contact would be "the charge nurse, OR supervisor, chief of surgery, chief of staff, and then to the medical staff leadership, credentials committee, and eventually the board of the hospital." Other readers countered that many hospitals lack such mechanisms. One nurse, who reported complications following her botched surgery by an older urologist, wrote that at 8 hospitals where she had previously worked, "no such 'system' is even vaguely in place." Another reader wrote that even with a protocol in place, the process "does not always result in what we feel are professionally responsible actions."

Unfortunately, the OR nurse in question stated only that concerns were reported to the "powers that be," without specifying who they were. Lacking this information, a large number of readers suggested contacting the chief of surgery first; additional recommendations included notifying other surgical colleagues, nursing supervisors, and anesthesia staff. There was essentially universal agreement with Ms. Buppert that the state medical board should be an option of last resort once all other internal mechanisms have been exhausted; as one commenter wrote, "the board takes so much time."

A final note of interest is the fact that the OR nurse chose to highlight the surgeon's advanced age. Several readers suggested that using this as the sole basis of complaint would be an inappropriate tactic. One reader pointed out that the complainant should be "objective and report the skill deterioration without mentioning age, as this opens the OR nurse up to age discrimination." Others commented that the complainant could also be considered "aging," with 42 years of experience as a surgical technician and registered nurse, and broaching the aging issue could result in accusations of hypocrisy. One physician asked whether it was "possible that the nurse's faculties have also changed over that period of time," whereas another physician in India said that the nurse's age also would have been grounds for retirement.

Red Flags for Aging Surgeons

Skills important to the performance of surgery -- strength, motor skills, visuospatial ability, and cognitive function -- all decline with advanced age.[17,27] Several surgeons who replied on Medscape reported other insights that ultimately led to their decision to retire or reduce operative volume voluntarily, including being "less able to cope with sleepless nights" and "trouble recovering from all-night surgery and working a full day the next day."

Recently developed initiatives such as the Aging Surgeon Program (Sinai Hospital, Maryland) and the Physician Assessment and Clinical Education program at the University of California at San Diego employ a blend of

interviews, cognitive and neuropsychological testing, and physical examinations and radiographs to identify potential red flags in aging surgeons that may warrant further intervention.[4,28] In the Aging Surgeon Program, one of the triggers for participation is reaching age 70 years or older upon each hospital recredentialing cycle.[4]

However, these programs do not automatically result in retirement or reassignment of an aging surgeon. Poor performance on these tests still warrants further discussion between the surgeon and the credentialing hospital on future employment outlook. Barring gross negligence or criminal behavior, the decision to retire still rests in the hands of the surgeon and requires substantial insight on his or her part. The words of one physician reader stand out: "If the surgeon makes the decision to retire, it is a happy ending."

References

1. Center for Workforce Studies. 2012 Physician Specialty Data Book. Washington, DC: Association of American Medical Colleges; 2012.
2. Carmel PW. Senior physicians keep working, putting off the R-word. American Medical News. April 30, 2012. http://www.amednews.com/article/20120430/opinion/304309967/5/ Accessed July 2, 2014.
3. Health Policy Research Institute. The Surgical Workforce in the United States: Profile and Recent Trends. Chapel Hill, NC: American College of Surgeons; 2010.
4. Katlic MR, Coleman J. The aging surgeon. Ann Surg. 2014 Mar 25. [Epub ahead of print]
5. Von Wachter T. The end of mandatory retirement in the US: effects on retirement and implicit contracts. Center for Labor Economics Working Paper no. 49. University of California at Berkeley. March 2002. http://www.columbia.edu/~vw2112/papers/vonwa_mr_2009.pdf Accessed July 10, 2014.
6. Sanford J. New policy to require evaluations for late-career practitioners. Stanford Medicine News. July 16, 2012. http://med.stanford.edu/news/all-news/2012/07/new-policy-to-require-evaluations-for-late-career-practitioners.html Accessed July 2, 2014.
7. Boodman SG. Aging doctors face greater scrutiny. Kaiser Health News.December 10, 2012. http://www.kaiserhealthnews.org/Stories/2012/December/11/aging-doctors-face-greater-scrutiny.aspx Accessed July 2, 2014.
8. Retirement age of medical teachers, doctors enhanced in Bengal. ZeeNews. May 26, 2014. http://zeenews.india.com/news/west-bengal/retirement-age-of-medical-teachers-doctors-enhanced-in-bengal_935057.html Accessed July 2, 2014.
9. Gadit AA. Should there be an age of retirement for the doctors? A matter for debate. J Pak Med Assoc. 2008;58:652-653. Abstract
10. Retirement age. Gov.uk. June 27, 2014. https://www.gov.uk/retirement-age Accessed July 2, 2014.
11. Agediscrimination.info. The finalised Employment Equality (Repeal of Retirement Age Provisions) Regulations 2011 are now out. March 4, 2011. http://www.agediscrimination.info/Pages/ItemPage.aspx?Item=353 Accessed July 2, 2014.
12. GP practices given green light to set mandatory retirement age for partners after landmark legal ruling. Pulse. May 4, 2012. www.pulsetoday.co.uk/gp-practices-given-green-light-to-set-mandatory-retirement-age-for-partners-after-landmark-legal-ruling/13897049.article Accessed July 2, 2014.
13. Aerospace Medical Association, Aviation Safety Committee, Civil Aviation Safety Subcommittee. The age 60 rule. Aviat Space Environ Med. 2004;75:708-715. Abstract

14. Ripple GP. Federal court: mandatory retirement age for pilots is not age discrimination. National Business Aviation Association. May 2, 2014. http://www.nbaa.org/admin/personnel/age-60/20140502-federal-court-mandatory-retirement-age-for-pilots-is-not-age-discrimination.php Accessed July 2, 2014.

15. Waljee JF, Greenfield LJ, Dimick JB, Birkmeyer JD. Surgeon age and operative mortality in the United States. Ann Surg. 2006;244:353-362. Abstract

16. Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. Ann Intern Med. 2005;142:260-273. Abstract

17. Waljee JF, Greenfield LJ. Aging and surgeon performance. Adv Surg. 2007;41:189-198. Abstract

18. Drag LL, Bieliauskas LA, Langenecker SA, Greenfield LJ. Cognitive functioning, retirement status, and age: results from the Cognitive Changes and Retirement among Senior Surgeons study. J Am Coll Surg. 2010;211:303-307. Abstract

19. Greenfield LJ, Proctor MC. Attitudes toward retirement. A survey of the American Surgical Association. Ann Surg. 1994;220:382-9; discussion 387-90.

20. Jackson & Coker Retirement Survey: an online research study. Jackson & Coker. August 2, 2011. http://www.jacksoncoker.com/documents/jcretirement_survey.pdf Accessed July 2, 2014.

21. Walker S, Poley S, Ricketts T; Health Policy Research Institute. The Aging Surgeon Population. Chapel Hill, NC: American College of Surgeons; 2010.

22. Federation of State Medical Boards. Policy on Physician Impairment. Euless, Texas: Federation of State Medical Boards of the United States, Inc.; 2011.

23. Kaups K, Orescovich M. Impaired physicians. Program and abstracts of the American College of Surgeons Leadership Summit. March 26-27, 2011; Washington, DC.

24. Hummer CD 3rd. The aging surgeon: how old is too old? AAOS Now [serial online]. May, 2007. http://www.aaos.org/news/bulletin/may07/managing4.asp Accessed July 2, 2014.

25. American Medical Association. Evaluating Impairment in the Senior Physician: Assuring Patient Safety and Physician Well-Being. AMA Online Learning Center. https://cme.ama-assn.org/Activity/2650392/Detail.aspx Accessed July 2, 2014.

26. Garrett K, Kaups KL. The aging surgeon: when is it time to leave active practice? Bull Am Coll Surg. 2014;99:32-35.

27. Blasier RB. The problem of the aging surgeon: when surgeon age becomes a surgical risk factor. Clin Ortho Relat Res. 2009;467:402-411.

28. Norcross WA, Henzel TR, Freeman K, Milner-Mares J, Hawkins RE. Toward meeting the challenge of physician competence assessment: the University of California, San Diego Physician Assessment and Clinical Education (PACE) Program. Acad Med. 2009;84:1008-1014. Abstract

Medscape General Surgery © 2014 WebMD, LLC

Cite this article: Gordon H. Sun. Clinicians Are Talking About Aging Surgeons. *Medscape*. Jul 21, 2014.