Respect Your Elders

To the Editor:

I read the article by Tessler[1] *et al.* and the accompanying editorial[2] with great interest, and applaud the investigation of such a controversial topic. Although the results presented in this study are novel with regards to increased litigation and severity of injury in anesthesiologists older than age 65, the concept of a decline in up-to-date knowledge in older physicians is not new. Studies evaluating the relationship between clinical knowledge and experience have demonstrated that the decline in knowledge seen in older physicians is associated with a decrease in quality of care.*

Day *et al.*[3] demonstrated that older physicians performed as well as their younger counterparts on examinations as long as the questions were directed at knowledge that had not changed since they were trained. Older individuals tend to rely on prior experience and pattern recognition, and have less of a tendency to incorporate new information into patient care.[4] Studies have shown that fluid intelligence (the art of reasoning) shows an age-related decline, whereas intelligence that is already solidified shows little effect with aging.[4] This continued incorporation of antiquated knowledge may lead to inaccurate decision making, diagnosis, and treatment.

Choudry[5] *et al.* found a negative association between length of time of practice (experience) or physician age and decreased factual knowledge, performance, and possibly poorer patient outcome. In addition, older physicians were less likely to adhere to agreed-upon standards of practice. Czaja[6] surveyed physicians to assess adherence to guidelines for cancer screening endorsed by the American Cancer Society and the National Cancer Institute. Physicians more than 20 yr out from primary certification were less likely to follow recommended practices.

The literature is replete with studies demonstrating declines in both knowledge and skill in the aging physician. Data demonstrate that physicians further away from their initial certification are in most need of nonself-made assessment.[7] Tessler *et al.*, through their thoughtful and courageous study, have now added important new concerns regarding the aging physician.

Perhaps the most controversial question that still remains unanswered, given abundant data to the contrary, is why the "grandfather status" remains? It is an honor and a privilege to have no defined retirement age in medicine. The American Board of Anesthesiology instituted the Maintenance of Certification Exam in 1999 expressly for the purpose of encouraging lifelong learning, improving the quality of physicians, and improving the quality of patient care. Allowing certain individuals, possibly those in most need of more "tailored educational experiences,"[2] to be exempt from having to participate in the Maintenance of Certification Exam process serves only to add question and skepticism to the validity of the entire recertification process.

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Anesthesiologist Age and Litigation: What Is the Association?

To the Editor:

Tessler *et al.* are to be congratulated for the innovative manner in which they have attempted to assess the effect of aging on physician competence, something about which many of us have concerns as we, and our colleagues, age.[1] However, I am somewhat surprised that in neither the article itself nor the accompanying editorial[2] is there mention of the significant differences in anesthesia practice between the United States and Canada or of the possibility that these differences might affect the authors' linkage of the aging of anesthesiologists with both the frequency of litigation and the severity of patient injury related to such lawsuits if applied to the U.S. practice model.

In Canada, except in teaching hospitals, anesthesia is given by personal administration, most often by anesthesiologists, but also, in rural hospitals, by specially trained family

* www.wolterskluwerhealth.com/News/Documents/White%20Papers/Evidence-based%20Resources%20to%20Improve%20Patient%20Outcomes.pdf. Accessed July 20, 2012.

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