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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physicians. In the United States, the supervisory model is used most often. Applying the metaphor in Warner's editorial, we could say that in Canada older anesthesiologists are "in the driver's seat," whereas in the United States, they usually are "backseat drivers" – involved in the crucial parts of the anesthetic but otherwise leaving patient care to the individual actually "behind the wheel." This difference in practice could affect the applicability of the findings of Tessler *et al.* to anesthesia practice in the United States, where the age and skills of the anesthesiologist are only part of the equation – where the experience and knowledge of the older anesthesiologist might well be of more consequence than his/her decreased attention span, possible visual/hearing impairment, longer reaction and processing times, or other factors that could be related to the increased "crash rates" of older physicians cited in the study.

As noted both by Tessler *et al.* and by Warner, there is sufficient research on this topic to establish that physicians do not age like fine wines.[3,4] However, especially in the absence of information as to what actions (or lack thereof) by the anesthesiologists involved lead to the lawsuits, this study is just the first step. As both Tessler *et al.* and Warner conclude, further research is essential – research based on the supervisory practice model that will help us determine just how and to what extent the observed correlation between anesthesiologist age and patient outcomes applies to practice in the United States.

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Take Away Some of the Keys

To the Editor:

The excellent article by Tessler *et al.*[1] and the accompanying editorial by Warner[2] offer an intriguing glimpse into one of many challenges confronting older anesthesiologists.[3] However, this study paints in broad strokes the issue of medicolegal experience that might obscure important details. The risk of suboptimal clinical outcomes and resulting litigation can be minimized if all clinicians, including older ones, limit their practice to exclude those procedures that they rarely perform. As demonstrated in a report on surgical mortality subsequent to various complex surgical procedures, older surgeons' age was not an independent predictor of surgical risk, provided that the surgeon maintained a high volume in those specific procedures.[4] On the other hand, bad outcomes occurred most frequently among older surgeons who maintained low volumes in those same procedures.

The study by Tessler *et al.*[1] failed to identify this potential confounding variable among their study subjects. Although the authors' analysis did account for overall clinical volume, the small numbers precluded further stratification to identify which of those bad outcomes occurred when older anesthesiologists were working outside their "comfort zone" – regardless of whether or not these were intrinsically complex cases or straightforward cases in unfamiliar patient populations (*i.e.*, pediatrics, bariatrics, obstretics, and so forth). The study of surgical mortality (previously cited) suggests that bad outcomes among older anesthesiologists could be minimized by stricter attention to case assignment. To extend Warner's analogy, maybe we should design ignition keys that restrict a senior citizen's access to a 4-cylinder pickup truck on a snowy winter evening as well as a 16-cylinder high-performance sports car on a sunny afternoon.

As suggested by the authors, these findings should inspire additional studies to examine what is a growing source of concern as our specialty continues to age.

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Maybe It Isn't Aging

To the Editor:

The report by Tessler *et al.*[1] and the accompanying editorial by Warner[2] cautiously examine the possibility that senior anesthesiologists, by virtue of age, pose a greater risk to patients. This natural concern is prompted by Tessler *et al.*'s finding that anesthesiologists older than 65 in the period between 1993 and 2002 incurred a greater risk of litigation than anesthesiologists younger than 51 yr.