The Ageing Anaesthetist

Richard Griffiths MD FRCA
Peterborough & Stamford Hospitals
I am not an expert in the field of cognitive decline in healthcare professionals.

I am grateful for the advice from Nancy Redfern, who is speaking at the meeting on a similar topic.

I hope to deliver some information on what the AAGBI is doing about working beyond 65, or 66 or 68 or 70?
Working Party

A new working party has started under the chairmanship of Professor Peter Huttton

“The Ageing Anaesthetist”
The On Call Room of the Future?
Executive Summary

Introduction

The expected physiological changes of normal ageing

The expected incidence and progression of illness with chronological age

The effect of age on clinical performance (including the positive and negative associations of working beyond the normal retirement age)

The current patterns and future projections of anaesthetists’ employment with age (survey to be undertaken via AAGBI)

The impact of demographic change in the general population on health service demand

Conflicts between ageing, retirement and managing an acute 24/7 clinical service

The impact of ageing, pension and retirement intentions on the future delivery of anaesthesia, intensive care and pain management
Ageing Anaesthetist

Issues
Pension age is rising, working longer

Population is also rising

Demands on services are increasing, can it be maintained?
Some Examples

Recent conversation with rota organiser in my hospital

“Do you mind working with a CT1 locum, until midnight, who is 73”

Anaesthetised a retired policeman who had received more pension than years he had worked (retired at 50)
Demographics

Figure 3: Estimated and projected population aged 70 and over, United Kingdom, mid-2012 and mid-2037

- Age 70-79: 4.5 million (2012), 5.8 million (2037)
- Age 60-69: 2.2 million (2012), 2.4 million (2037)
- Age 90-99: 0.5 million (2012), 0.6 million (2037)
- Age 100 and over: 0.1 million (2012), 0.2 million (2037)
Demographics

Figure 1: Estimated and projected age structure of the United Kingdom population, mid-2012 and mid-2037
## Demographics

Table 4: Projected population by age, United Kingdom, mid-2012 to mid-2037

<table>
<thead>
<tr>
<th>Ages</th>
<th>2012</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
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<td>30-44</td>
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<td>12.7</td>
<td>13.3</td>
<td>13.6</td>
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<td>75 and over</td>
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<td>5.5</td>
<td>6.6</td>
<td>7.7</td>
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<td>85 &amp; over</td>
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<td>All ages</td>
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<td>68.0</td>
<td>70.0</td>
<td>71.7</td>
<td>73.3</td>
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<td>Median age (years)</td>
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<td>3.29</td>
<td>3.39</td>
<td>3.08</td>
<td>2.76</td>
<td>2.74</td>
</tr>
</tbody>
</table>

Table notes:
1. * Working age and pensionable age populations based on State Pension age for given year. Between 2012 and 2018, State Pension age will change from 65 years for men and 61 years for women, to 65 years for both sexes. Then between 2019 and 2020, State Pension age will change from 65 years to 66 years for both men and women. Between 2034 and 2046, State Pension age will increase in two stages from 66 years to 68 years for both sexes. This is based on State Pension age under the 2011 Pensions Act.
Pensions

66 by 2020

68 for all public sector workers by 2046

New consultant (34), will retire in 2048 (68)

Medical student (18), will retire in ? (75)
Covers cognitive decline

Sleep

Effect of on call

Ability to process new information

Differences in learning
Physiological Changes

All systems decline

Sight

Hearing

Appearance of long term conditions

World best 1500 times Men
When do things start to go wrong?

The first law suit?

The first pair of varifocals?

The first anti-hypertensive?

The inability to remember drug doses?
The NHS Franchise System

- No two hospitals are the same
- 4 NHS systems in England, Wales, Scotland, Northern Ireland
What is Already out there?

AAGBI publication on Working arrangements for consultant anaesthetists?

Useful guide, some information on on call arrangements
The AAGBI has recommended that “there should be a review of on-call responsibilities for anaesthetists over 55 years of age” [6]. Consultants have no right to drop on-call duties at a set age, as this would be contrary to UK age discrimination legislation, but CDs should consider reasonable requests to discuss on-call duties from older members of the department. Small
A sliding scale of intensity: novel rota system for consultant delivered care

Authors: A Plunkett, R Mildner, F Reynolds, K Morris
Publication date: 31 Aug 2012

A Plunkett and colleagues describe a new rota system for implementing consultant delivered care in acute hospital specialties.

In its 2012 report *Shape of the Medical Workforce* the Centre for Workforce Intelligence estimated that if junior doctors continue to be recruited and trained on the current trajectory, the number of hospital consultants will increase by more than 60% by 2020.[1] The report presented a number of scenarios to confront this potential oversupply of consultants, including moving to a “consultant delivered” or “consultant present” model of service.[1]

Consultant delivered care

A system of consultant delivered care carries many potential benefits, not least of which is the promise of an improvement in patient care and safety. The Academy of Medical Royal Colleges’ independent, systematic review of the topic concluded that medical care delivered by consultant hospital doctors may improve clinical outcomes for patients, improve training of junior doctors, and lead to more efficient use of healthcare resources.[2] The Royal College of Paediatrics and Child Health has also emphasised the potential benefits of consultant delivered care in its 2012 report *Consultant Delivered Care*,[3] which concluded that “children would receive better care if they had 24/7 access to a consultant or equivalent senior doctor.”

Concerns have been raised, however, about the financial implications of consultant delivered care in terms of salary costs. Although these costs may be offset by increased efficiency of healthcare resources and improved patient care and safety, the financial cost of implementing consultant delivered care would undoubtedly increase. The 60% more consultants predicted by the Centre for Workforce Intelligence could cost the NHS £6bn a year in salaries by 2020—£2.2bn more than in 2010.[4]
agreed by the team, and the sliding scale of intensity rota system was successfully implemented.

Fig 1 Split of high intensity (first on-call) and low intensity (second on-call) shifts as a proportion of consultants' direct clinical care programmed activities.

Fig 2 Intensity of on-call shifts for a single consultant, modelled over a career of 25 years.

Conclusions
Sensible Option

The Sliding Scale of On Call

BMJ Careers 2012

Birmingham PICU

Changes during career, heaviest burden is on the younger members
24/7

Will need more senior presence during weekends and Bank Holidays

May reduce out of hours operating

Consultants now have the burden of delivery of this type of care
EDITORIAL II

Is a consultant-delivered anaesthesia service feasible or desirable?

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Consultant led and delivered services
Increasing patient access to specialists is important, but new ways to do this need to be found

Nigel Edwards senior fellow
King's Fund, London W1G 0AN, UK
Emergencies February since 1992

Figure 3: Senior Anaesthetist at Operation by Year

CONSULTANT
SHO

CEPOD

EWTD 56 hours
Change in Workload

Most emergencies are now conducted by consultants

This includes surgeons

Evidence comes from a number of sources
ASAP, NELA
ASAP Data 2013

Regions

Consultant/Specialist Supervision

Anaesthesia and Orthopaedic surgery
Table 2  Time of day, seniority of medical staff, and 30 day mortality. *Time of anaesthetic induction

<table>
<thead>
<tr>
<th>Time of day*</th>
<th>n</th>
<th>Consultant anaesthetist present (%)</th>
<th>Consultant surgeon present (%)</th>
<th>30 day mortality (%)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>80.8</td>
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</tr>
<tr>
<td>18:00–23:59</td>
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<td>54.8</td>
<td>67.7</td>
<td>17.8</td>
</tr>
<tr>
<td>00:00–07:59</td>
<td>152</td>
<td>40.8</td>
<td>61.8</td>
<td>20.3</td>
</tr>
</tbody>
</table>

Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network

D. I. Saunders¹, D. Murray²*, A. C. Pichel³, S. Varley³, C. J. Peden⁴, on behalf of the members of the UK Emergency Laparotomy Network

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Burden of Healthcare

More older people

Pension burden high

Long term conditions well managed

Lots of common conditions
Burden of Healthcare

Large bowel mitotic disease

Primary hip and knee arthroplasty

Revision hip and knee arthroplasty

Fragility fractures
Estimates of the Very Old (including Centenarians), 2002-2012, England and Wales

Coverage: England and Wales
Date: 27 September 2013
Geographical Area: Country
Theme: Population

Key Points

- In 2012 there were estimated to be 465,500 people aged 90 and over living in England and Wales, just under 1% of the total population.

- Between 2002 and 2012 there has been a 33% increase in the number of those aged 90 and over.

- In 2012 in England and Wales, the number of centenarians (those aged 100 and over) was estimated to be 12,320.

- There were estimated to be 2.6 women per man aged 90 and over and 5.9 women per man aged 100 and over in England and Wales in 2012.
Figure 1: Population aged 90 and over, 1981-2012, England and Wales

Source: Office for National Statistics
Projected incidence of proximal femoral fracture in England: A report from the NHS Hip Fracture Anaesthesia Network (HIPFAN)

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ARTICLE INFO

Article history:
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Keywords:
Hip fractures
Economics
Epidemiology
Mortality

ABSTRACT

Aims: This study was designed to estimate trends in the number of proximal femoral fractures (PFFs), and consequent bed day requirements and financial implications for England until 2033.

Methods: Trends in the number of coded PFFs from 1998 to 2008 (collected from Hospital Episode Statistics Online) were projected forward to 2033, and modified according to published data concerning population demographics and declining PFF prevalence. Estimates of 30 day postoperative mortality were calculated according to projected demographic data. Financial estimates were calculated according to current cost and adjusted according to projected inflation.

Results: Despite a decline in the prevalence of PFF among the aging population (2.98% since 2002), we estimate that approximately 100,000 patients annually will require surgery for fractured neck of femur by 2033 in England, with a 30d mortality of 8.9–9.3%, costing £3.6–5.6 billion (inflation adjusted) in total care.

Conclusions: The evaluation and implementation of cost-effective preventive and therapeutic strategies in the short term may help to ameliorate the future financial burden of PFF, and, more importantly, improve the outcome and quality of life for the elderly after fracture.

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Projected incidence of proximal femoral fracture in England: A report from the NHS Hip Fracture Anaesthesia Network (HIPFAN)

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ABSTRACT

Article history:
Accepted 19 November 2010
Keywords:
Hip fractures
Epidemiology
Economics

Aim: This study was designed to estimate trends in the number of proximal femoral fractures (PFFs), and associated bed day requirements and financial implications for England until 2033. Methods: Trends in the numbers of cases (79,155 from 1998 to 2007 obtained from Royal Orthopaedic Hospital Trust) were projected forward to 2013, and modified according to published data concerning population demographics and declining PFF prevalence. Estimates of 365 day post-operative mortality were calculated according to projected demographics. Financial restraints were calculated according to expected care and adjusted according to expected tariffs. Results: When projected forward to 2033, the total estimated PFF cases (2,000,000) will result in an economic cost of approximately £1 billion. Approximately 100,000 admissions annually will require care for the fractured neck of femur by 2033 (national, with a median age of 85.3 years in 2008, rising to 86.3 by 2033). Conclusion: The estimation and implementation of cost-effective preventive and therapeutic strategies in the short term may help to alleviate the future financial burden of PFF and, more importantly, improve the outcome and quality of life for the elderly after fracture.

Fig. 1. The calculated projected change in PFF numbers in England over the next 25 years. The solid line represents increases calculated by applying the current age group annual incidence of PFF/100,000 patients (Table 1) to ONS population predictions; the dotted line represents the current annual rate of rise of PFFs projected to 2033; the dashed, lower line represents a projection that incorporates the fall in annual incidence of PFF among the over 60 s (Fig. 1) if this fall were to continue at the current rate.

Fig. 2. Age-grouped numbers of hospital admissions for PFF in England in 2008 against the projected figures calculated for 2033.
NUMBER OF PATIENTS

Years: 1987 to 2013

Number of Patients:
- 209 in 1987
- 486 in 2013
Proximal Femoral Fractures

• 2008 to 2033 population of England will rise by 22%
• population over 60 will rise from 22% to 28%
• this is a numerical increase of 50%
• average age of the hip fracture patient will rise by 1 year for every 5 years
• 81 in 2008 (ASAP 2013, 82)
• 86 in 2033
Numbers

• Peterborough, medium to large DGH will be treating 1,000 hip fractures per year in 2030 (16 years from now)

• A new medical student just starting will be a new consultant (specialist)
Lots of Work

Need to work longer to pay for those who have retired already

Other factors
Population predictions need to be accurate
Health Workforce planning
Association between Anesthesiologist Age and Litigation

Michael J. Tessler, M.D., * Ian Shlirer, M.D., Ph.D., † Russell J. Steele, Ph.D. ‡

ABSTRACT

Background: The threat of being sued is a concern for many anesthesiologists. This paper asks whether litigation brought against anesthesiologists is associated with the age of the anesthesiologist.

Methods: Institutional research ethics approval was granted. We obtained billing data for all procedures performed by specialist anesthesiologists stratified into three age groups (less than 51, 51–64, and 65 and older) from British Columbia, Quebec, and Ontario for the 10-yr period from Jan. 1, 1993 to Dec. 31, 2002. We also obtained all litigations (including disability weighted claims) handled by the Canadian Medical Protective Association during the same time period in which the Canadian Medical Protective Association experts considered the anesthesiologist cited to be at least partially responsible for the adverse event leading to the complaint.

Results: In univariate analysis with the least than 51 age group as the reference category, the litigation rate ratio for the 51–64 age group was 1.14 (95% CI: 0.99–1.32) and for the 65 and older age group was 1.50 (95% CI: 1.14–1.97). Our analyses using disability weighted claims showed the 51–64 group to have 1.31 (95% CI: 0.95–1.80) and 65 and older group to have 1.94 (95% CI: 1.41–2.67) relative increase in disability compared to the less than 51 age group.

Conclusions: We found a higher frequency of litigation and a greater severity of injury in patients treated by anesthesiologists in the 65 and older group. The reasons for these findings should become an active field of research.

A regional survey of anesthesiologists in New England reported that older anesthesiologists work fewer hours per week and were more stressed by liability concerns when compared with younger anesthesiologists. We wondered what the risk of litigation is among different age groups of anesthesiologists for a given clinical exposure. Thus, the objective of this paper is to determine if there is an association between anesthesiologist age and litigation in patients undergoing anesthesia.

Materials and Methods

The Research Ethics Committee of the SMBD-Jewish General Hospital (Federalwide Assurance Number: 0796) (Montreal, Quebec, Canada) granted approval of the study.

◊ This article is featured in "This Month in Anesthesiology."
Fig. 1. The total number of specialist anesthesiologists (A), number of legal claims (B), number of procedures (C), and legal claim rate (D) for each age group (less than 51: dashed, 51–64: dotted, 65 and older: solid) are shown for each year between 1993 and 2002. Although the number of claims is much less for the older age group, the number of exposures is also much less. Therefore, the claim rate for the 65 and older age group is generally higher in each year.
The aging anesthesiologist: Are we asking the right question?

Robert Byrick, MD

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Kahneman, a Nobel laureate, recognized that we all have intuitive feelings and opinions about almost everything and it is our natural inclination to believe that we are rarely totally “stumped”. When a satisfactory answer to a complex question is not readily available, a common intuitive human response is to find a related question that is easier to answer. In this issue of the journal, Baxter et al. address an important topic that relates to the professionalism of anesthesiologists in dealing with age-related decline in clinical performance. The authors offer a “proactive” strategy that hospital departments and practice groups should consider for managing this issue. They identify that many anesthesiologists wish to continue in practice beyond age 65 and that the ability of physicians to self-assess has been found to be inadequate to protect patient safety. We have to ask whether this lack of ability to self-assess is limited to this age group (there is abundant evidence that this shortcoming is not age-dependent) and whether the proposed strategy would be expected to improve overall patient safety.

The rationale for undertaking Baxter’s review was partly related to the findings by Tessler et al. that aging anesthesiologists (i.e., older than 65 yr) have 1.5 times the risk (after adjusting for exposure) of being found responsible in litigation when compared with their younger colleagues. Importantly, the degree of injury, as defined by the financial awards associated with the litigated cases, was greater in patients of the older anesthesiologists. Tessler acknowledged that his methodology, and hence his conclusions, had limitations due to the low frequency of litigation in clinical practice, the unknown work environment of the different groups, and the unknown underlying mechanism for increased risk. He speculated that the increased risk among older anesthesiologists could have been related to easier fatigueability, resulting in reduced vigilance, longer response times, less continuing education, or poorer communication skills. Ever commented that another confounding factor may have been that the two groups (i.e., older than 65 and younger than 65) were fundamentally different in their training and skill set right from the outset of their professional careers. When dealing with sensitive social and legal issues, we all agree that we must be careful not to draw possibly erroneous conclusions about individuals based on statistical analysis of groups.

There are, however, other data that support Tessler’s conclusion that the age of anesthesiologists is a contributing factor to a decline in favourable outcomes in clinical practice. For example, Campbell et al. reported that 52% of patient complaints to the General Medical Council in the United Kingdom (UK) involved anesthesiologists qualified for more than 20 years, whereas only 39% of the cohort were over the age of 45. Baxter et al. have asked an important, yet complex, question that requires serious analysis. We cannot, and should not, deny that there may be an unrecognized problem pertaining to some anesthesiologists that is related to an age-related decline in clinical abilities. Nevertheless, in order to develop a strategic approach to enhance patient safety, we need to identify the nature, extent, and consequences of the problem as well as the solution.

The authors review physiologic changes that occur with aging and speculate that the cause of the increased risk to patient safety may be perceptual limitations (e.g., hearing or visual deficiencies) or cognitive decline, which would influence judgment and decision-making. They propose...
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 insures 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 anesthesiology 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).

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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 dyscompliance. 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)
Summary of USA Conference

Ageing

1. Wide variety of physiological changes
2. Changes are variable and individual
3. Assessment programs do exist and should be used
4. Mandatory age rules should not be employed
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.
Like to see more done by the employers to address the issue

Editorial

The ailing anaesthetist

The medical profession has been described as “one of the most unattended populations in terms of health” [1]. There are many probable reasons for this, not least the lack of awareness and understanding of occupational health. The forthcoming publication of Occupational Health and the Anaesthetist by the Association of Anaesthetists of Great Britain & Ireland (AAGBI) [2] is to be welcomed, therefore. It provides a comprehensive practical guide to the role and remit of the occupational health services of the

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AAGBI Occupational Health Guidelines
Summary

Demographic change important

Society

Profession

20 year gap year starts soon (RG)