When Is it Time to Retire?

by Nicole Li, JD, MBE
Coopersmith Health Law Group

Physicians are often compared to airline pilots: both professions require intensive training and bear significant responsibilities for public safety. Unlike physicians, however, commercial pilots must undergo regular health and performance assessments and are not permitted to stay in the profession after the age of 65. Physicians, on the other hand, can practice as long as they meet the minimum requirements to renew their medical license.

Other than meeting these minimum requirements, a physician's fitness to practice relies largely on self-assessment. While physicians recognize their duty to report colleagues whom they suspect to be incompetent or impaired in some way, when concerns arise in actual practice, many physicians are reluctant to do to so.[1] This disinclination has many sources, including the belief that someone else would address the problem.

Relying on self-assessment and informal collegial reporting is risky, particularly when the possible cause of sub-optimal performance flows from aging. Practice style and personal manner often improves with the years, after all. Respect, compassion, and deference likely factor into the hesitation that physicians may experience when the colleague of concern is older.

After intense training and work, one's identity and self-esteem are entwined with one's profession. Perhaps more than any profession, it is difficult to retire from medicine.

The natural decline in cognitive and motor skills may be brought to our attention by kindly (or not-so-kindly) hints from friends and family. These inevitable changes can affect physicians' proficiency and judgment as well as their ability to keep current with best practice standards. Aware of aging, some physicians gracefully and even gratefully relinquish some or all of the high-pressure aspects of their jobs; others resist, sometimes to their own and their patients' detriment.

We all know doctors who treat patients for many decades with great skill, with a loyal following of patients and peers. The confidence and authority that comes with experience engenders trust, which itself brings comfort to patients. Trust facilitates care. Age alone clearly cannot be the determinant of competence.

Yet a recent Harvard study found an inverse relationship between years of clinical experience and quality of care provided.[2] By every measure across 32 studies, including medical knowledge and adherence to standard of care guidelines, the performance of more-experienced physicians compared unfavorably to that of their younger colleagues. Of course, some aspects of medical practice are either unquantifiable or have not been studied in isolation: the therapeutic value of a physician's personality, judgment, and innate manner are of course worthy of recognition.

According to a study published in the American Journal of Medicine, 6.6 precent of physicians out of medical school for 40 years face disciplinary action, compared with 1.3% of their colleagues who graduated only 10 years ago.[3] The Journal of the American Medical Association had previously reported a positive association between disciplinary action and being in practice more than 20 years.[4] These studies received renewed attention following the

1 *Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues.* DesRoches, Catherine M et al, *JAMA.* 2010;304(2):187-193.

2 Systemic Review: the relationship between clinical experience and quality of health care. Choudhry NK, Fletcher RH, Soumerai SB. *Ann Intern Med.* 2005 Feb 15; 142(4): 260-73. Available at: *www.annals.org/cgi/content/full/142/4/260*

3 *Disciplinary action against physicians: who is likely to get disciplined?* Khalig AA, Dimassi H, Huang CY, Narine L, Smego RA Jr. *Am J Med.* 2005 Jul;118(7):773-7.

4 Physicians disciplined by a state medical board. Morrison J, Wickersham P. *JAMA.* 1998 Jun 17;279(23):1889-93. Available at: *http://jama.ama-assn.org/content/279/23/1889.long*

FIRST PRINTED IN THE JUL/AUG 2011 "BULLETIN" VOL. 90 NO. 4 REPRINTED WITH PERMISSION OF THE KING COUNTY MEDICAL SOCIETY

American Medical Association's report that one in five physicians in the United States is over the age of 65.[5] These rates should be viewed not only for what they say about quality of care, but also for their impact on physicians themselves. It can be devastating for an established physician to face investigation, let alone sanction. To have the honors, awards, and admiration that often come with decades of professional service be overshadowed by a single incident that was found to be below the standard of care is tragic.

The enormous changes that technology has brought to the practice of medicine may be behind some of the troubles that long-practicing physicians encounter. Not only is the method of record-keeping evolving as electronic systems are more widely adopted, but the standards for required content have increased. Staying current with best practices and new medications demand that physicians continue learning throughout their careers. Completion of the minimum CMEs are insufficient.

Medical practice is transformed by both technological advances and public policy shifts. Many physicians have been highly critical of health care reform, with a 2009 poll indicating that 45% of doctors would choose early retirement rather than work under a different system.[6] Given that the profession is changing so rapidly, why do some physicians choose to work into their seventies and eighties?

As noted earlier, being a physician is often integral to identity and self-worth; but the answer to this question may also be financial. The perception that doctors make a lot of money is not often accompanied by the recognition that doctors, especially in independent or small practices, must spend a lot of money as well: the cost of running a medical practice continues to spiral.

Rather than maintain independent practices, increasing numbers of physicians are choosing to join large groups or hospital systems. As this trend continues, the pressure on groups and hospitals to address the need for viable competency checks on physicians will grow. Large groups and systems often adopt practice standards; in the case of hospitals, they have peer review and medical executive committees that enforce the standards. Accrediting agencies, such as The Joint Commission, also identify processes to recognize and manage individual physician health to ensure patient safety.

It is difficult to measure some aspects of physician skill. Many factors contribute to surgical outcomes, for example, that are beyond a physician's control. Other parts of a physician's practice, however, can be objectively assessed. Regular audits of physician record-keeping can raise alerts to potential problems. Encouraging a non-confrontational culture where nurses and other staff can express concerns to the group or hospital may also help. The creation of dignified ways for older physicians to make the transition from the high-pressure portions of practice should be considered, perhaps by establishing programs that allow them to get involved in management or mentoring.

Public focus, prompted not only by regulators and payers but also by patient advocates and social commentators, is on linking physician reimbursement to quality of care. In this environment, the medical establishment cannot afford to continue avoiding the formation of stronger standards for competency evaluation. In the absence of guidelines to determine what level of cognitive decline affects patient care, regulatory authorities are necessarily reactive. It would be better for the medical profession if it leads the way on establishing methods and protocols to determine fitness to practice, rather than letting non-physicians do so. A peer-driven assessment prior to problems arising is preferable. Physicians are more likely to address patient safety in a way that properly respects long-practicing colleagues and clinical criteria.

Like athletes, physicians should know when to leave the field. Timing, in this regard, can be everything. ■

This article does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to the appropriate attorney.

5 *https://catalog.ama-assn.org/MEDIA/ProductCatalog/m1990045/PCDSamplePgs2010.pdf*

6 *www.investors.com/NewsAndAnalysis/Article.aspx?id=506199*