The Aging Physician

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"And yet the wiser mind mourns less for what age takes away than what it leaves behind."

This quote was taken from William Wordsworth's examination of mortality in his "Matthew" poems. This complex and vaguely contradictory prose is a fair metaphor for the difficulties inherent in the consideration of aging in the physician population.

A national census of actively licensed physicians found that 23% are age 60 years or above. This number will grow rapidly with the graying of the baby boomer population. Additionally, physicians, like the rest of the population, are living longer. Along with the personal identity and professional satisfaction associated with practicing medicine, practical considerations influence the length of a physician's career. For example, 52% of physicians changed their retirement plans in response to the recent and protracted economic recession.

Aging is associated with an increased risk for developing a number of conditions that can affect cognition, such as dementia, stroke, diabetes and cardiovascular disease. Sensory and motor impairment occur with macular degeneration, orthopedic injury and hearing loss as well as general neurodegenerative processes. Older people are more vulnerable to the cognitive and systemic effects of acute illnesses such as infections.

The wisdom that accompanies experience is invaluable. Older physicians generally maintain the body of their medical knowledge. Decades of experience allow them to draw on thousands more patient experiences than younger physicians who have recently completed training. It is important to appreciate the difference between crystallized and fluid cognitive ability when assessing an aging physician. Crystallized cognitive ability is associated with learned and acculturated knowledge. In contrast, fluid cognitive ability involves novel or abstract problem solving. With normal aging, it is common to lose some fluid cognitive ability while crystallized cognitive ability is preserved. For this reason, an older physician may function impressively well performing familiar procedures, including complex ones. However, deficits in fluid ability may manifest when the same physician is presented a new task or one that is complicated by urgent and competing demands occurring simultaneously. For this reason, mixed age practices are ideal.

A physician's ability to deliver competent medical care can generally be determined by colleagues who work closely with the physician. However, for an older physician with a smaller panel of patients who is not involved in the cross coverage of colleagues' patients, detecting cognitive impairment (which often develops insidiously) may be delayed. Solo practice and/or working in more isolated (rural) areas can further complicate the detection of incipient health problems.

Understandably, physicians who witness the cognitive decline of an elderly colleague may hesitate to intervene related to sympathy for that individual and/or a wish to preserve the physician's integrity. Importantly, confronting a physician who has demonstrated lapses in performance is not easy. The initial effort may be met with strong denial and resistance. For this reason, dismissing the lapses in ability or even compensating for the physician's decline are common actions taken by concerned colleagues and other members of a medical team. A 2010 JAMA article represented that one third of physicians who had known a colleague was impaired (for any cause) failed to report their concerns.

Numerous studies reveal that advancing age is associated with an increased rate of discipline among physicians. However, it is unclear whether the correlation is related to the risks for complications/complaints inherent in having treated a large volume of patients over an extended period of time or age-related decline, cognitive or otherwise. Additionally, as physicians age, at least in most specialties, so do their long-term patients. Older patients tend to have multiple medical problems that are more complex, heightening the risk of error, relative to a younger demographic of patients.

Concerns regarding competency often uncover underlying cognitive disorders. A study of 267 physicians referred to a doctor-assessment center found that 24% of them showed some degree of cognitive difficulty requiring further neuropsychological evaluation. In contrast, a control group of 68 physicians undergoing the same cognitive screening showed no cognitive impairment. Cognitive deficits should be considered in those physicians who fail to remediate despite good effort.

Physicians belong to a safety-sensitive profession. Like pilots, physicians require similar sensory and motor skills coupled with the ability to make rapid decisions in stressful situations. The Federal Aviation Administration requires pilots to undergo medical and cognitive screening at age 40 and mandates retirement at age 65. Air traffic controllers must step down by age 55. No such mandates exist for physicians, or Supreme Court Justices, for that matter! However, there is a growing trend among hospitals to pursue cognitive screening in the course of credentialing doctors over the age of 65. An abundance of cognitive screening instruments are available to assess basic cognitive abilities. These include the Folstein Mini-Mental Status Exam, the Montreal Cognitive Assessment, the MiniCog and computerized screening such as the MicroCog. However, many of the screens available (with the exception of the MicroCog) are normed for high school graduates, not physicians with baseline high intelligence in addition to 23-plus years of education and training. For this reason, a physician typically has more cognitive reserve relative to others. Subtle deficits may escape detection with most screens which lack sensitivity and specificity. Other factors may confound screening results, including the expected anxiety associated with this degree of scrutiny and potential negative implications of abnormal findings. Because most cognitive disorders progress insidiously, the affected physician and his/her colleagues may not recognize deficits until they are severe and impairing.

If significant deficits are detected on a screening examination, physicians are typically referred for more comprehensive neuropsychological testing which can provide more sensitive and specific information concerning the physician's strengths and weaknesses. Importantly, reversible causes for the deficits such as obstructive sleep apnea, hypothyroidism or B12 deficiency, to name a few, must be ruled out. Mild Cognitive Impairment (MCI) is a condition characterized by cognitive abnormalities that do not meet the full criteria to establish a diagnosis of dementia. Physicians meeting criteria for MCI may be allowed to work with certain accommodations. However, the physician would also require ongoing health monitoring due to the high likelihood of MCI progressing to full dementia. Eighty percent of individuals with MCI develop dementia over a period of six years.

Medical boards, certifying bodies such as the American Board of Medical Specialties and other credentialing entities are beginning to explore ways to incorporate health screening into the process of maintaining licensure and demonstrating competency beyond successful performance on recertification examinations. Eventually, some health screening is likely to be required of physicians in line with other safety-sensitive professions. Rather than identifying impairment through patient driven complaints (i.e. after harm has likely occurred and when physician discipline is likely to result), a proactive confidential process should be developed to allow for the early detection of cognitive illness, expedient treatment as well as a thoughtful fitness-for-duty evaluation. In the end, competent practice rather than age-adjusted performance needs to be the standard maintained.

A collaborative effort between cognitive specialists, physician health programs, medical boards and certifying boards will be required to develop a thoughtful process for assuring public safety without imposing unnecessary or discriminatory restrictions on older physicians. Physicians with decades of experience and contribution deserve the same sensitivity and respect afforded their patients as they experience health changes that may or may not allow continued clinical practice.

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