There has been interest, of late, on just what to do with old docs. A resolution at the AMA annual meeting in 2015 suggested that standards should be relaxed, to make it possible to retain more older physicians.\(^1\) This was defeated. That’s probably for the best. Lowering standards past some age, say 60, would send a very bad message. On the other side of the question, there continue to be advocates for stricter treatment of older physicians. The reasoning is that since physicians may lose some faculties with age, all physicians should be tested for loss of mental faculties. Perhaps there should be a mandatory retirement age. It works for pilots, doesn’t it? Checklists can be helpful in both practicing medicine and flying airplanes, right? But the similarities pretty much start and end with checklists.

Nonetheless, the argument for mandatory retirement has a certain amount of appeal. There are institutions, both academic and non-academic, that require retirement at a certain age, usually 65. But … do they, really? Such requirements are often highly selective. If the administration of a university decides you’re making sufficient money, or bringing prestige, or generating grant income, you may find yourself at the grindstone well after you begin drawing Medicare. Whatever their stated principles, most institutions are coldly pragmatic. The whole idea of mandatory retirement is simply a way of easing some older physicians out while retaining others who still have value to the institution. Why retire the aged goose who is still laying golden eggs? Assessment of competence is flexible, after all.

A few statistics might be in order. There are, at last count, about 900,000 licensed active physicians in the US.\(^2\) The physician supply is growing at about 2-3% per year. So, how many practicing physicians are elderly? (Who you calling elderly, sonny boy?)

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A 2015 report by the AMA Council on Education concluded that physicians should meet the same standards of competence, whatever their age.\(^4\)

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Ahem.) Some 30% have passed their 60th birthdays, and 10% are 70 or older. We have a physician shortage, which is estimated to grow to 46,000 to 90,000 by 2025, most of which will be in primary care specialties.\(^3\) Mandatory retirement even at 70 would drop the numbers of practicing docs by 90,000. That would seem to be a poor policy choice. But just because it’s dumb, don’t rule it out. Consider the number of good policy choices that have been made in health care over the last 10 years or so. Good choices are pretty thin on the ground, and are clearly outnumbered by the rest.

The AMA has adopted a middle position on the issue of older physicians. A 2015 report by the Council on Education concluded that physicians should meet the same standards of competence, whatever their age.\(^4\) Seems fair enough. Does this resolve the issue? Well … not really. Consider surgeons. Dr. Mike DeBakey operated into his 90s. Most of us are not so skilled. Or so valuable to our institutions. All of us lose some of our stamina as we age, even though we may still be skilled. Staying up all night to operate, for example, becomes more difficult to endure. So … should a 70-year-old continue to take trauma call? A 65-year-old? Granted, it depends on the individual. But how do we know? How does the surgeon himself or herself know? We all keep track of outcomes, now, especially in trauma. But it may take several years for enough poor outcomes to accumulate to mandate a decision.

PERSONAL DECISION

Such things as peer review, maintenance of certification, keeping up on CME activities, and attending conferences are probably helpful. But we all know older physicians. Some of us are older physicians. Do we follow them around, looking for mistakes? I can testify that as you get older, you do ask yourself if you should be continuing in practice. Speaking personally, I stopped operating a year...
or two ago, but I still see patients on a part-time basis. This was with the advice of my colleagues. But it was basically a personal decision, made on my best judgement. Judgement, of course, is the very thing that might be failing. I like to think my judgement is pretty good. Or I wouldn’t still be writing editorials. But then, so does everyone, even politicians. Especially politicians. Some, obviously, are wrong.

The truth is that we depend largely on the judgement and the conscience of the individual physician in these matters. Most of us, and I say this on the basis of long observation, do a pretty good job at making the call about when to slow down and when to stop entirely. Inevitably, a few of us do not. Figuring out who those few are, and easing them into retirement, will remain difficult.

Maintaining uniform standards for all ages, as the AMA advocates, is certainly a good thing to do, and is necessary. But is it sufficient? In that 2014 survey, 54% of practicing physicians were over 50. They will be entering their 60s and 70s over the next 10 years. With a growing physician shortage, it will be very tempting to keep these old warhorses in harness. And really, we need them. Every time a physician retires, we lose 30, 40 or 50 years of experience.

Finally, there is a legitimate fear that too many older physicians will respond to the current trends in health care by simply quitting. In the last issue of Kansas City Medicine, we published an editorial on physician burnout. The number of doctors who have talked, written, or e-mailed me about this issue is sobering. To reprise the conclusion of that piece, we must strive to make working conditions better for physicians. Otherwise, a lot of us are going to retire, or at best go into non-practice jobs. But health-care reform will require increasing numbers of practicing physicians. The manpower loss could be crippling. In short, we need older docs. And we need to keep them happy. Or the rest of us will be even more stressed in 10 years than we are now.

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