

New guidelines uphold lifelong competency of surgeons

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As millions of Americans approach age 66, they face the inevitable question, is it time to retire? The physician population is aging alongside the general population—more than 40% of physicians in the U.S. will be 65 years or older within the next decade. In the case of surgeons, there is little guidance on how to best ensure their competency throughout their career and at the same time maintain patient safety while preserving physician dignity.

In a [study](#) published in the *Journal of the American College of Surgeons*, the American College of Surgeons (ACS) Board of Governors (BoG) Physician Competency and Health Workgroup seeks to provide answers to the old-age question. They have developed a strategy for sustaining lifelong competency, an evidence-based roadmap for the surgery community and their institutions of practice to support the current and future generations of surgeons throughout their careers.

"Research shows that, as people get older, both motor and [cognitive capabilities](#) tend to decline," said lead author of the study Dr. Todd K. Rosengart, professor and DeBakey-Bard Chair of the Michael E. DeBakey Department of Surgery at Baylor College of Medicine. "This decline can impair a surgeon's clinical performance below the level of acceptable competency."

Although currently there are recommendations for transitioning of the senior surgeon that include mandatory cognitive testing beginning at the age of 65 years and career transition planning beginning at least in mid-career, the logistics of when and how to address these issues and how to

maintain and support the competency of surgeons throughout their careers are less clear.

"In comparison, other professions such as the aviation industry have rigorous guidelines, including annual certification requirements and even mandatory retirement, which we are not recommending, to ensure the competency of their workforce and the safety of the lives entrusted to them," said Rosengart, who also is vice chair of the ACS BoG Physician Competency and Health Workgroup.

"The strategy proposed in this study supports comprehensive, multimodality clinical lifelong competency assessments for physicians of all ages that would include neurocognitive testing and the early implementation of long-term transition planning for surgeons within a culture of safety, collaboration and equity. Furthermore, we propose implementing strategies that sustain lifelong or career-long competency."

"Being a physician is often at the core of a surgeon's identity, and developing pathways that foster the maintenance of cognitive skills in an inclusive and non-judgmental framework is essential to the maintenance of such competency," Rosengart said.

"We need to empower our surgeons to be involved in their own assessments of competency throughout the entirety of their careers as opposed to focusing on the trigger of age," said Dr. Adam M. Kopelan, co-author of the work and chair of the ACS BoG Physician Competency and Health Workgroup. "By doing so, we can help destigmatize the concerns of aging on performance." Kopelan also is chair of the Department of Surgery and director of surgical services at Newark Beth Israel Medical Center in New Jersey.

An evidence-based strategy

The ACS does not support a mandatory retirement age, according to this study. Research shows that the onset and rate of age-related decline in clinical performance varies among individuals and suggests that objective assessment of fitness should supplant consideration of a mandatory retirement age.

The authors indicate that while there isn't a mandatory retirement age for U.S. physicians, many other countries, such as India, China, Spain and Australia, impose a mandatory retirement age.

While there are studies showing a correlation between increased age with decreasing medical knowledge, lower adherence to evidence-based standards of care and worse patient outcomes, other studies found that the greater experience of older versus younger surgeons can offset at least some of the effects of cognitive decline.

"Some of these studies show that older surgeons can perform better in terms of outcomes because they've learned through years of experience about how to avoid trouble, how to navigate complex cases or the like," said Rosengart.

The authors also acknowledged studies suggesting that surgeons may not, on their own, recognize deterioration of their physical and cognitive function and clinical skills with age. Potential warning signs of age-related decline may include forgetfulness, unusual tardiness, evidence of poor clinical judgment, major changes in referral patterns, unexplained absences, confusion, change in personality, disruptiveness, drastic change in appearance and unusually late and incoherent documentation.

"A significant number of physicians surveyed at the ACS annual meetings were not aware of their own cognitive decline, nor were many peers comfortable, understandably, calling them out and saying, 'I'm concerned about my colleague,'" said Rosengart. "The ability to create a

framework where we normalize taking care of ourselves and each other in a non-pejorative way is very important."

"Another important part of this study is that it addresses the question of who is going to lead this effort. Is it going to be the American College of Surgeons, the American Board of Surgery or other state or national entities?" Rosengart said. "If we abdicate this responsibility, is it going to be the federal government mandating what we do? Surgeons should take the leadership role in developing competency assessments and associated policy."

The study also considers the issue that motor and cognitive decline are likely to be different for every surgeon. The strategy the authors propose allows for the flexibility needed to support each surgeon's particular situation because one size does not fit all.

"Importantly, though, evidence of decline can also signal an opportunity for individualized training, which in at least some cases has been shown to reverse or at least slow neurocognitive declines and potentially extend a surgeon's service as an active operator," Rosengart said.

"We are not proposing that a cognitive test would be the one and only standard of approving competency," Rosengart said. "We propose a mosaic of cognitive testing, including clinical performance, peer review and so on, that would be potentially different at each institution. And what we're going to do, hopefully, is create guidelines and a framework for institutions to decide for themselves what that competency testing and approval should look like."

The authors propose to focus on a surgeon's [competency](#) throughout the entire career in combination with long-term transition planning so that surgeons are prepared should testing and other factors indicate a transition away from standard clinical practice.

"Up until now, surgeons have not had that awareness of, yes, this will come to an end, and you need to be prepared," Rosengart said. "What we envision is early career considerations of, 'What am I going to do when I can't or wish not to go to the [operating room](#)?'"

A senior surgeon can continue to contribute meaningfully in many diverse ways. One could serve as a first assistant to a more junior surgeon who could benefit from that surgeon's skills and experience. Another surgeon might feel ready to leave the operating room arena and continue being an active member of the hospital in other ways, for example in quality improvement, research, education, mentoring or coaching, or community outreach.

"Too often surgeons think, 'The day I leave the operating room is the day my life as I know it has ended,'" Rosengart said. "That can be frightening. We want to change that next chapter into something that physicians and surgeons will welcome as a new opportunity."

More information: Todd K Rosengart et al, Sustaining Lifelong Competency of Surgeons: Multimodality Empowerment Personal and Institutional Strategy, *Journal of the American College of Surgeons* (2024). [DOI: 10.1097/XCS.0000000000001066](https://doi.org/10.1097/XCS.0000000000001066)

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