Sixty-five is the time.

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In state service in South Africa, retirement is mandatory for doctors at 65 years while in private practice retirement age is not regulated. Is surgical retirement age an issue? Professor Michael DeBakey famously continued to operate until he was 90. Surely a lifetime of experience offsets the inevitable decline in motor and cognitive function that comes with age? There is however a growing body of evidence that physician experience and age is linked to worse patient outcomes. In one meta-analysis, 74% of studies showed a negative association between physician age and recognized standards of therapeutic care. 1

Discussions regarding retirement are ever more necessary as the number of elderly surgeons increases. In Australia 19% of active surgeons are older than 65 years of age. 2 In the United States, in a study assessing the cognitive function of older surgeons with a mean age of 67 years, 33% of participants had plans to retire within 5 years while 30% had no plans to retire. 3 While this study did show that older practising surgeons were as good as their younger contemporaries, who were 41 to 59 years of age, in terms of cognitive function we know older surgeons are much less likely to offer laparoscopic surgery 4,5 or immediate breast reconstruction for their patients. 6 Even when older surgeons do take on a new treatment modality such as laparoscopic inguinal hernia repairs, their recurrence rates are higher than their younger colleagues. 7 Outcomes such as mortality have also been shown to increase related to surgeon age for both carotid endarterectomy 8 and coronary artery bypass grafting. 9 While a newer study added pancreatectomy to that list, the authors did attribute the worse outcomes shown by surgeons older than 60 to decreased individual surgeon performance age was between 35 and 50 years. 10

It should also be remembered that the prevalence of dementia in those under 65 is 4% but rises to 15% between 65 and 74 years of age. 11

Transitioning out of a career focused on operative surgery needs to be managed well. Surgeon volume independent of hospital volume is directly linked to outcomes in major surgery. 12 A larger teaching or administrative role also needs to be well considered given that many studies have shown that elderly practitioners are not up to date with current guidelines. 1

As an aside, after I had proposed mandatory retirement in a debate at a national meeting, I was approached by a recently retired surgical mentor who proffered in all earnestness the question. “Would you have your Whipple done by me or the young whipper-snapper fellow?” In the interest of not offending sensibilities I obviously replied “of course it would be you Prof…” However had I time to gather my thoughts I would have replied, “I would like to have my neuroendocrine pancreatic tumour resected in your unit as it is a high volume centre with a multidisciplinary team assessment process and good published outcomes. I would like the “younger” experienced surgeon in your team to perform the operation under your tutelage, safe in the knowledge that watching a surgeon evolve past your skill level is where true satisfaction lies.”
REFERENCES


