CORRESPONDENCE

“Winding down” guidelines for anesthesiologists: The Ottawa Hospital plan

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Received: 6 June 2016/Revised: 13 June 2016/Accepted: 21 June 2016/Published online: 21 July 2016
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To the Editor,

In a previous *Journal* article by Baxter *et al.*,¹ we described the effects of aging on anesthesiologists and suggested strategies to deal with such issues towards the end of one's career. It was hoped that this would increase awareness and provoke discussion, both locally and at higher levels. Subsequently there has been a “panel discussion session” at the 2015 annual meeting of the Canadian Anesthesiologists' Society,² an article in the 2016 Canadian Medical Protective Association newsletter,³ and most recently by the President of the Royal College of Anesthetists in the College Bulletin earlier this year.⁴

An example of a template for discussion was initially described in the Baxter *et al* article,¹ and your readers may be interested to learn how we have now applied it here at The Ottawa Hospital. The Anesthesiology Department Human Resources Committee was tasked with producing a policy document on phased retirement framework guidelines, a draft of which was circulated to all department members. The vast majority of respondents agreed with it. For those who did not, their concerns were addressed, the document was modified where appropriate, and more detailed explanations were given where necessary. After it was presented at a recent department meeting, with some further minor modifications made, the final document ([Appendix](#)) was approved after a department-wide vote.

In brief, variability in the aging process was acknowledged when making these “guidelines”, with

various changes in practice activities to be at least considered at various age prompts (e.g., consider stopping “overnight on-call” at age 60 yr, no further high acuity cases at age 65 yr, retirement from main operating room practice at age 70 yr). Simulation training is recommended to enhance the ability to recognize and deal with crises in the operating room for OR anesthesiologists every five years and annually at age 60 yr.

Other departments may have differing perspectives on this issue, but clearly it needs to be addressed as the anesthesiology staff ages. We encourage the topic to be discussed locally. This document is another example of how it is possible to address this difficult issue.

Conflicts of interest None declared.

Editorial responsibility This submission was handled by Dr. Hilary P. Grocott, Editor-in-Chief, *Canadian Journal of Anesthesia*.

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Appendix

TOH Anesthesiology Departmental End-of-Career Management “Phased Retirement Framework Guidelines”

If we are fortunate to live a long time, all of us must eventually retire.¹ We spend a great deal of energy learning and practicing Anesthesiology, but little emphasis has been placed on planning and managing an exit strategy for a satisfying, respectful end of career. Retirement should be voluntary and planned, a reward to a successful career in Medicine. The purpose of these guidelines is for individuals to thoughtfully plan for this stage with the best interests of the individual, the Department, and the patient.²

Cognitive function and clinical abilities can unfortunately decline as we age, without clear overt deterioration in skills, and we are more likely than younger colleagues to be involved with adverse events, patient harm and litigation. Physicians have been granted the privilege of self-regulation. Decisions about reducing activities and retirement have largely been left to the individual, despite limited ability to self-assess competence, and this may be associated with adverse events and poor patient outcomes. The CPSO has a peer assessment program to evaluate physicians at random, after a complaint, and at certain ages, but the tools have limitations. Anesthesiologist performance may not be well reflected in chart and 360° review, especially crisis recognition and management, which are crucial in anesthesiology. Hospital departmental performance review for reappointment includes several facets (CME review, interview with Site Chief, SIMS data, 360° review), but again does not well assess crisis recognition and management.³ Simulation may meet this need, and could be used to improve crisis management. All faculty anesthesiologists should maintain and hone their crisis management skills regularly, perhaps annually.

Most Anesthesiologists already reduce their activities as they age, but a standardized winding down of practice would have advantages for the individual physician, the Department, and the patient. For the physician, this would facilitate personal planning with less uncertainty about the end of career period, stress reduction, and protection from certain caseload work in which they may be less comfortable. The Department will benefit from the continued presence and practice of elderly physicians (less stressed, mentoring other members), and improved HR succession planning. For the patient, this approach should translate into potential improved safety. If an adverse event does occur despite these recommendations, the physician and the department will have shown a

responsible approach and insight into this aspect of the work activities of individuals towards the end of their careers. Areas to consider in standardized winding down guidelines include: a shorter work week, elimination of overnight shifts, a gradual reduction in responsibilities, and/or a change in scope of practice. Narrowing or limiting scope of practice from high acuity cases that require rapid cognitive processing should be considered, together with other aspects of anesthesia practice which have a higher frequency of sudden and challenging cardiovascular and respiratory emergencies (consideration of more time scheduled for the assessment of patients with complex medical problems, e.g. in PAU.)

The weakness of self-assessment limits the effectiveness of some of these suggestions. In the absence of national or provincial direction, the Department has developed these structured winding down guidelines for the unique practice of Anesthesiology with the following goals:

- Respect for the individual must be maintained during the period of phased retirement, and job satisfaction must be optimized during changes in clinical activity.
- The department will assist with the appropriate assessments for all to ensure fitness to practice, and will conduct the appropriate performance evaluations internally.
- The older anesthesiologist may reduce activities earlier than the following timelines, within the limits of departmental policies, or if necessary as the result of deterioration in clinical skills.
- There could be greater flexibility in work after age 60, with perhaps the possibility of taking time off in discussion with Department.
- The older anesthesiologist will be assigned work with a case pattern to be determined in discussion with the Site Chief and Department Head. This could include assigned Residents or Fellows for sub-specialty experts for high acuity cases for the educational program.
- Assistance for any anesthesiologist will be provided when there is an expected or unplanned clinical need, and the older anesthesiologist (>60) will not be scheduled for situations where this is not possible e.g. overnight on-call activities. Late shift assignments with these members need to be planned and discussed (e.g. end of day assignments may place individuals in higher risk areas with less support available e.g. code 333 for member who may not have recent experience in OB).
- In the absence of overt deterioration in skills, he/she will not be scheduled for overnight on-call duties after achieving the age of 60 (to avoid interrupted sleep, stress of higher case acuity, limited help available to deal with crises). Partnerships may allow

for this at an earlier stage as per their current practice

- The Anesthesiologist will retire from Main Operating Room clinical practice after achieving the age of 70. If desired, this may be replaced with non-operating room clinical or non-clinical activities - Pre-anesthesia Assessment Unit, administration, research, mentoring, education, etc.
- Members in different phases of winding down their career are encouraged to mentor individuals getting close to phased retirement period. This could include advice on financial planning (and also for new recruits) and changes in practice, so that a staged reduction in practice is optimized. This can be done individually, or with intra-departmental retirement planning meetings.
- All members of the department will undergo simulation training at a minimum of every five years as an educational initiative

References

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Age (years) prompt	Suggested Practice Activities
>55	<ul style="list-style-type: none"> • formal discussion with Head to discuss scope of practice going forward
>60	<ul style="list-style-type: none"> • no further overnight on-call duties (to avoid interrupted sleep, stress of higher case acuity, limited help available to deal with crises) • recommend annual simulation CME to practice crisis management
>65	<ul style="list-style-type: none"> • no further high intensity/high acuity cases • recognized subspecialty experts may consider continuing with appropriate high acuity cases with assigned Residents or Fellows
>70	<ul style="list-style-type: none"> • retirement from Main Operating Room clinical practice • if desired replace with non-operating room clinical or non-clinical activities - Pre-anesthesia Assessment Unit, administration, research, mentoring, education, etc.