From the Flight Deck: This is Your Captain Speaking

Tamara R. Fountain, MD

"Experience is important because other people's lives are at stake, but the unfortunate thing about experience is you have to get older to get it."

— Bert Yetman
Retired Southwest Captain and Air Force fighter pilot.

I fly a lot. I'm in the air as I write this. When I deplane I'll try to peek in the flight deck to see who just delivered me safely to my destination. I may see a man; I may see a woman. I may see a pilot who is White, Black, Asian or Latino. What I won't see, at least here in the US, is a pilot over the age of 64. The Federal Aviation Administration (FAA) mandates retirement for all "air transport" (meaning commercial passenger carrier) pilots on their 65th birthday. Until 2007, the mandatory age of retirement for US pilots was just 60 years of age. A pilot who wanted to keep flying either moved or commuted overseas to fly for foreign carriers who had higher age restrictions and coveted the experience and discipline of US-trained aviators.

The "Age 60-rule," was in force when my father, a former US Air Force instructor pilot, was forced to retire from Northwest Airlines in 2000. He became part of an organized challenge that eventually extended the mandatory retirement age. He and several of his 60-65 year old retired pilot cohorts across the country submitted to a battery of cognitive, physical and psychometric testing. The assumption that older pilots were less capable than their younger cohorts was not supported by the evidence. The Aerospace Medical Association concluded in a report to the US Senate's Committee on Aging that there was "insufficient medical evidence to suggest restriction of pilot certification based on age alone."

A retrospective study, commissioned by the FAA in response to this growing movement, showed the highest number of aviation accidents were among pilots aged 24-39. Pilots 55-65 years old had virtually none. Though there was an increase in accidents when pilots approached age 70, the rate was still significantly lower than that of the 24-39-year-old group.

Laurie McCann, an attorney for AARP who filed several friend-of-the-court briefs on behalf of the pilots noted, "Age 60 was an arbitrary figure and [mandatory retirement] should be based on an individual's ability to do the job."

Health care, like aviation, is a highly-regulated industry. We doctors, however, are under no federal mandates to shut down our practices on a certain birthday. This may be changing. The American Medical Association's house of delegates voted in June 2015 to approve a report proposing systematic fitness for duty testing of older physicians. The 21-page report from the AMA's Council on Medical Education referenced 72 peer-reviewed papers in concluding that advancing age diminishes a physician's abilities. While it didn't offer specifics on who or how the tests would be administered, the report did recommend that testing include an evaluation of physical and mental health. A review of doctors' treatment of patients is also part of the report's recommendation.

The number of physicians 65 and older has quadrupled since 1975. It is estimated that almost 100,000 remain involved with patient care and 10,000-15,000 are still operating surgeons. Not waiting for the AMA recommendations and recognizing potential liability, a large consortium of California hospitals has, with backing from legal counsel, published a guidebook that outlines specific legally-defensible steps medical boards and other oversight committees can take to screen the competency of older doctors.

The Ophthalmic Mutual Insurance Company (OMIC), which

offers professional liability coverage to eligible AAO members, has 857 (18.3%) policyholders over the age of 65 (August 31, 2015). The oldest insured is 90 years old. The company's underwriters collect date of birth on all applications and require all policyholders, regardless of age, to divulge any medical conditions that could impair their ability to practice.

Self-reporting is presumed to be an adequate option for policing physician performance, but by and large, hospitals and outpatient surgical facilities remain primarily responsible for monitoring continued physician competency as part of the credentialing process.

Just as I take comfort that my pilot has passed ongoing and rigorous classroom and cockpit competency testing, don't my patients deserve the same level of confidence in my surgical and diagnostic skills? Regardless of age, I would like to think I would have the insight to recognize (and report) my own impairment. But what if I won't? What if I can't? On the other hand, I'm not sure how I'd react to a mandatory expiration date on my career either-we know from our own patients that not all 65-year-old patients are created equal. In the name of public health, I would not object to standard testing of ALL physicians on some schedule starting in mid-career.

We should take patient safety as seriously as we take airline passenger safety in this country. The debate continues on how to assure the fitness of US doctors throughout their careers. Is self-reporting an unrealistic expectation? Should physicians, like other professions charged with public safety, submit to mandatory fitness testing? Should there be a mandatory retirement age? As my flight attendants prepare the cabin for landing, I'm keeping my seat belt buckled low and tight across my lap. Like the issue of physician testing, there may be turbulence ahead.

As I Remember It

Sound Sleeper

George H. Kurz, M.D.

Late one night during my senior year of residency at the University of Pennsylvania (1959-1960) I had to go to the morgue to remove a pair of donated eyes. I brought the eyes in sterile jars to the eye ward and began searching for the list of patients waiting to have corneal transplants. Unable to find a list, I had two choices: I could send the eyes to the eye bank, which was located at Wills Eye Hospital (the competition) and risk the wrath of the professor the next day, or I could call the professor at home and risk his wrath for waking him late at night. I chose the latter.

"Dr. Scheie," I began when he answered the phone, "This is George Kurz. I'm on the eye ward with two postmortem eyes that I've just removed. Would you like me to send them to the eye bank

or do you have a list of patients waiting for transplants?" If he didn't have the actual list at home, at least I thought he could tell me where to look for it on the ward. I was prepared to call the first two names on the list and alert them to come to the hospital first thing in the morning, ready for surgery. But there was no response. Not a sound at the other end of the line, except Dr. Scheie's heavy breathing.

Dr. Scheie was well known for his ability to survive on four to five hours of sleep a night. He went to bed early, before midnight, but was up long before dawn to review his ophthalmology journals and the like. What I didn't know was what a sound sleeper he was during those few hours. "Dr. Scheie, do you know where the transplant list is?" I persisted. Again, no response. He must have fallen back to sleep before I had finished the second sentence. "Dr. Scheie! Dr. Scheie!" I called. Still no response. I pictured him there sound asleep with the phone off the hook. If I hung up and tried again, his line was going to be busy. I was stuck. "Dr. Scheie! Dr. Scheie!" I yelled a few more times, but to no avail. I gave up, hung up the phone, and put the eyes away in the ward refrigerator. The next morning was sure to bring a "Why didn't you...," but I couldn't think of anything else to do.

As usual at 7 a.m. the following morning Dr. Scheie appeared on the ward. With some trepidation I told him about the eyes in the refrigerator. He made an immediate decision to send them to the eye bank. Either there was no waiting list or his schedule was so full that day that he couldn't possibly fit in a corneal transplant or two. He gave not the slightest hint of recalling my phone call during the night.

Life's Embarrassing Moments

M. Bruce Shields, MD

Before embarking on a career in ophthalmology, I served a short stint in the Navy as a general medical officer. It was during the Vietnam War, and I chose the submarine service as the lesser of several evils. Our submarine was moored in Holy Loch, Scotland, where we spent a month in preparation before going out for a two-month (all under water) patrol. Across the loch (a Scottish term for a lake that is connected to the sea) was an old stone church (or "kirk" as the Scots would *(Continued on page 9)*