### Title

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### Journal

American Journal of Geriatric Psychiatry, 26(2)

### ISSN

1064-7481



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### Publication Date

2018-02-01

### DOI

10.1016/j.jagp.2017.08.003

Peer reviewed

# Successful Aging of Physicians

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Don't retire. And if you must, retire much later than age 65.

—Shigeaki Hinohara, MD[1]

By 2030 the proportion of the world's population over age 65 will double that of 2000.[2] As the society ages, demands on healthcare services and providers will increase dramatically. This has led to a growing interest in and importance of the aging physician. There is a need for physicians and other clinicians to provide care for the growing population of older adults. Interestingly, the number of all actively licensed physicians in the United States older than age 60 has increased from 24% in 2010 to 31% in 2014, suggesting that many older physicians are deferring retirement.[3,4]

There have been several prime examples of successful occupational aging of physicians. Dr. Shigeaki Hinohara (1912–2017), a world renowned Japanese physician, who is credited with building the foundation of Japanese medicine, continued seeing patients until months before his death at age 105. He published several books, including *Ikikata Jozu* (*How to Live Well*), discussing the importance of living positively in old age. He urged older adults to contribute to the society using their wisdom and experience and advocated for delaying retirement as long as possible. Similarly, Dr. Michael DeBakey (1908–2008), a Lebanese-American cardiovascular surgeon who pioneered cardiopulmonary bypass surgery and invented a number of devices to help heart patients, maintained an active work schedule well into his nineties.

The article by Wijeratne et al.[5] in this current issue is timely. These authors examined factors associated with successful aging (SA) among 1,048 Australian physicians aged 55–89 years and found that occupational SA rates were higher than personal SA rates, although the two types of SA were strongly intercorrelated. Making work adaptations (e.g., reducing work hours, referring out patients, planning for retirement, enhancing leisure time) was associated with worse occupational and personal SA. Finally, occupational and personal SA were predicted by almost the same factors, including older age; urban practice; not intending to retire; greater physical, cognitive, emotional, and motivational resources; less depression; higher work centrality; and greater anxiety about aging.

These findings highlight what has been anecdotally observed in aging physicians, including Drs. Hinohara and DeBakey, that personal and occupational SA are strongly entwined, reflecting that physicians' personal sense of purpose and self is associated with professional success. The authors raise the concept of occupational identity: the conscious identification of oneself as a worker. This construct has been conceptualized as a core element of identity and a strong contributor in the emergence of meaning and structure in individuals' lives.[6] For many physicians their occupation is not just a job but a career or a calling, for which the prevailing work motivation is intrinsic.

Our own research on SA in community-dwelling older adults has shown that resilience and a sense of engagement, reflected in the pursuit of continued stimulation, learning, feeling a sense of purpose in life, and being useful to others and society, are the most prominent aspects of self-rated SA.[7] For physicians, these qualities are inherent in their line of work, further bolstering their occupational identity. Consequently, as Wijeratne et al. have reported, work adaptations such

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http://dx.doi.org/10.1016/j.jagp.2017.08.003

as reducing clinical practice or retirement planning may be perceived as a sign of not only occupational but also of personal failure. The dread of retirement may be linked to the fear of becoming irrelevant, or, stated another way, continuation of work is rooted in a desire to maintain relevance. Of note, the authors interpret the relationship of increased work adaptations with worse occupational and personal SA as a paradox, expecting that physicians who were aging more successfully would make active changes to their practice, enhance their time doing leisure activities, and begin planning for retirement. However, their interpretation assumes that these behaviors influence perception of SA, rather than considering the alternative possibility that aging may affect behaviors. Thus, physicians who are aging less successfully (e.g., with medical morbidity) may be forced to make such changes. Of course, because the data were cross-sectional, directionality of these relationships cannot be determined. As other research has shown, the most relevant qualities to SA include personal mastery/growth, positive adaptation, life satisfaction, emotional well-being, and active engagement with life despite having common age-associated illnesses and physical disabilities.[8] Thus, encouraging a positive sense of engagement through work among aging physicians may enhance their self-perceived SA.

The aging of physicians has an important social impact on the growing healthcare demands of an aging population. Wijeratne et al.'s study is useful in understanding SA among physicians and has set the stage for future work in this area. Much of the discussion in the literature surrounding aging physicians concerns fitness for duty, that is, whether older physicians have cognitive and motor skills to continue to provide safe and competent care. Some reports have suggested an association between increasing physician age and poorer clinical performance and quality of care.[9] However, the association between age and clinical performance is complex and influenced by many professional (e.g., complexity of the patients treated) and personal (e.g., physical disability) factors, and the overall published data are mixed and inconclusive.[10] Other potential concerns that have been raised include a risk for professional burnout and depression, which can be associated with deterioration in the physician–patient relationship and decrease in both the quantity and quality of care. Interestingly though, studies have reported that late career physicians are generally the most satisfied ones and have the lowest rates of distress compared with early- and mid-career physicians.[11] This is consistent with findings of improved mental health and psychosocial functioning with aging in the general population.[12]

Older physicians bring valuable skills, clinical expertise, wisdom, and life experiences that can be obtained only through years of practice. Senior physicians are critical to training new generations of physicians and can be a great inspiration to other professionals. Dr. DeBakey no longer operated in his advanced age but continued to give lectures, teach, and travel to build cardiovascular centers across the world. Dr. Hinohara published numerous books after his 75th birthday. Although their roles might change with age, the contribution of aging physicians to medical practice and teaching is undeniable. Moreover, these positive role models challenge the societal stigma of aging as being synonymous with disease and disability. They also suggest that a physician's identity should not be tied solely to her or his work in terms of clinical care but may include activities that contribute to the society in other ways, such as mentoring, consulting, and, in general, offering experience-based wisdom to younger generations.

## References

1. Gillett R: A Japanese doctor who studied longevity—and lived to 105—said if you must retire, do it well after age 65. Available at: www.businessinsider.com/doctor-who-studied-longevity-dont-retire-2017-7. Accessed July 28, 2017.
2. Centers for Disease Control and Prevention: Trends in aging—United States and worldwide. MMWR Morb Mortal Wkly Rep 2003; 52:101–104, 106
3. Young A, Chaudhry HJ, Thomas JV, et al: A census of actively licensed physicians in the United States, 2012. J Med Regul 2013; 99:11–24
4. Young A, Chaudhry HJ, Pei X, et al: A census of actively licensed physicians in the United States, 2014. J Med Regul 2015; 101:8–23
5. Wijeratne C, Peisah C, Earl J, et al: Occupational determinants of successful aging in older physicians. Am J Geriatr Psychiatry 2017.
6. Skorikov VB, Vondracek FW: Occupational identity. In: Schwartz S, Luyckx K, Vignoles V, eds. Handbook of Identity Theory and Research. New York, NY: Springer, 2011:693–714
7. Jeste DV, Depp CA, Vahia IV: Successful cognitive and emotional aging. World Psychiatry 2010; 9:78–84

8. Montross LP, Depp C, Daly J, et al: Correlates of self-rated successful aging among community-dwelling older adults. Am J Geriatr Psychiatry 2006; 14:43–51
9. Choudhry NK, Fletcher RH, Soumerai SB: Systematic review: the relationship between clinical experience and quality of health care. Ann Intern Med 2005; 142:260–273
10. Kupfer JM: The graying of US physicians: implications for quality and the future supply of physicians. JAMA 2016; 315:341–342
11. Dyrbye LN, Varkey P, Boone SL, et al: Physician satisfaction and burnout at different career stages. Mayo Clin Proc 2013; 88:1358–1367
12. Thomas ML, Kaufmann CN, Palmer BW, et al: Paradoxical trend for improvement in mental health with aging: a community-based study of 1,546 adults aged 21–100 years. J Clin Psychiatry 2016; 77:e1019–e1025