LETTERS TO THE EDITOR

I write following my reading with great interest the published article "Physicians and Cognitive Decline: A Challenge for State Medical Boards," in the *Journal of Medical Regulation.*[1]

I express my opinion based on my own personal experience as an active practicing physician for 47 years across several states.

I agree with the article's author that "older physicians benefit from their many years of experience and the skills they have developed over decades of practice…," but feel that the use of the generalization that these physicians "may be at risk of cognitive decline, with job performance deficits…," may be biased and inaccurate. Such a conclusion could raise concern as not based on significant statistical facts and/or factual finding.

We cannot and should not generalize, otherwise our opinions become skewed and invalid.

State Medical Boards and Peer Review Boards have their own internal review procedures for checks and balances. They are the regulatory and monitoring authorities overseeing physician performance practices, treatment outcomes, physician patient satisfaction, medical errors, negligence, reporting of patient loss, including outcome of claims litigation.[2,3,4]

Having an outside source beyond internal affairs of State Medical Boards and Peer Review Boards mingle and interfere with their internal and intrinsic procedures, proceedings, legislation, and medical staff by-laws seems like an intrusion by telling assigned medical organizations how to oversee, regulate, and proceed in these matters that are akin to physicians telling state bars how to regulate their member lawyers.[2,4,6]

State Medical Boards do identify, monitor, and pursue physicians who show cognitive decline. These bodies already do a good amount of regulating and overseeing of Quality Assurance, as is the case of the Medical Board of California, following their legal state mandate and ethical obligation to the public and its trust.[7]

Many State Medical Boards and Medical Associations have adopted certain methodology to establish such programs. They also have the wisdom to screen and monitor physicians to establish such programs, and the wisdom to screen and monitor physicians' late impairment through specific Medical Specialty Tests and comprehensive follow-up tests to best identify any such issues.[2,4,6]

There is no set or agreed upon age when such physicians' testing program should commence. Due process and its protections are paramount for the process of identifying physician impairment and performance below the standard of care, so that the process can be fair, reasonable, and equitable to all.

State medical societies already institute public relations campaigns geared to build support among clinicians and other professional medical organizations, as its relevance also applies to State Medical Boards, who are tasked with regulating and overseeing medical and health care providers as well.[5]

Cognitive decline is not exclusively or only inherent to medical practitioners. It also applies to all in the work force, across the board. The dos and the don'ts are ultimately a matter of due process and the law.

Letters to *JMR* are welcome. Letters should reference material previously published in *JMR* and should not exceed 400 words and four references. Letters being considered for publication are shared with the author(s) of the published material that is referenced, and the author(s) will have the opportunity to reply. Letters to the editor must include the writer's address and phone number. Letters may be edited and shortened for space.

Send your letter to editor@fsmb.org

Given the current physician shortage crisis we are facing in the US, along with the demographic trends, more primary care providers are likely to be needed to meet the increasing needs of the older population, and the need to avoid forced early retirement of aging, elder physicians in this country.[5]

Ultimately, competence rather than mandatory retirement due to age per se should be the deciding factor regarding whether physicians should be able to continue their practice.[4]

Physicians recognize that they are not alone, and the visible leadership by influential national organizations and accrediting bodies (eg, National Academy of Medicine, American Medical Association, Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, the Joint Commission, American College of Physicians, Accreditation Council for Continuing Medical Education) engaging regulators, payers, and other organizations may provide optimism for meaningful change.

Respectfully Submitted,

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References

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