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The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

THE AGE ISSUE

AGING POPULATION RISING WHILE PHYSICIANS ARE AGING OUT OF PRACTICE

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Editor / Executive Director
Jennifer Mills

Research Student Aide
Sangya Sharma

Design / Layout
Scribner Creative

EXECUTIVE OFFICE:

1811 Tower Drive, Suite C
Monroe LA, 71201

phone 318.512.6932
fax 318.450.3237
email director@ouachita**ms**.org

www.ouachita**ms**.org

OUACHITA MEDICAL SOCIETY

MISSION STATEMENT

The Ouachita Medical Society is a service organization of physicians dedicated to the ideal of a community that is mutually beneficial to physicians and patients.

THE SOCIETY COMMITS ITSELF TO THESE GOALS:

1. To pursue and maintain access to quality medical care
2. To promote public education on health issues
3. To provide value to members by the representation and assistance of member physicians in the practice of Medicine

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AS THE YEAR DRAWS TO A CLOSE WITH THIS ISSUE OF THE HIPPOCRATIST, I WOULD LIKE TO THANK THE CONTRIBUTING AUTHORS OF THIS ISSUE, AS WELL AS THE AUTHORS OF THE FALL-WINTER ISSUE, FOR THEIR TIME AND EFFORT.

The Ouachita Medical Society had a wonderful holiday season with our Christmas Party, followed by the Mardi Gras Oyster Party in February. I would like to offer a special thank you to Dr. Amber Shemwell and her husband, Clay for hosting the Christmas Party in their lovely home. The event drew a large crowd with many old and new members attending! As always, Thurman had a wonderful array of food. The Oyster Party is always well-attended and this year was no exception. We had to bring out extra food!!! Catfish Charlie's, as always, did an outstanding job with all of the seafood! Bayou Landing is a great venue to catch up with old friends as well as meet new ones. The OMS would like to give a special "thank you" to Origin Bank and Argent Financial Group for annually sponsoring this event.

We are also grateful to LAMMICO for sponsoring our Spring Meeting, which was held on May 30th at Bayou DeSiard Country Club Courtyard this year. The topic presented by Dr. Kenneth Rhea, qualified for one hour of CME with respect to LAMMICO's Risk Management Credit.

Our Fall meeting will also be at Bayou DeSiard Country Club. The topic will be the State of Health Care.

I would like to thank Jennifer Mills, our new Executive Director, who has done a fantastic job this year!

This issue of The Hippocratist addresses the aging general population, as well as the aging of the physician workforce. According to Merritt Hawkins, since 2011 about 10,000 Baby Boomers turn 65 each day in the United States. These seniors compromise 14% of the population, but account for 34% of inpatient procedures and 37.4% of diagnostic tests. These percentages will increase over time.

The notion that we should be training more primary care physicians while maintaining or reducing the supply of specialists is a grave miscalculation. According to Merritt Hawkins, we should be training both types of physicians.

When the topic of physician shortages arises, much attention goes to the primary care physician, internist and pediatrician, and with good reason. The demand for these types of doctors is high, and the supply is limited. But it is a mistake to believe shortages are confined to primary care. The Association of Medical Colleges (AAMC) projects that there will be around 105,000 too few physicians by 2030 (and it only gets worse), including 48,000 too few primary care doctors and 62,000 too few specialists.

Demands for specialists will be driven by patient demographics, as more Baby Boomers turn 65. Most of these will need specialists to care for ailing organs, bones, vascular systems, nervous systems, psyches and other aging issues. Advances in medical technology and a desire for cutting edge care will increase the demand for specialists.

The nation's Baby Boomer physician workforce is aging along with the larger population. Forty-three percent of all physicians are age 55 or older. Specialists, on the average, are older than primary care doctors. Seventy-three percent of pulmonologists and 60% of psychiatrists are age 65 or older, compared with 40% of internists and 38% of family practice doctors. Advances in diagnostic technology and the increased use of Physician Assistants and Nurse Practitioners can help address the shortage in primary care, but are less likely to reduce the need for specialists. The nation is going to need more specialists as well as primary care physicians.

Dr. H.G. "Vau" Taliaferro

RESIDENT'S VIEW

A LOCAL LOOK AT AGING

Rhiju Poudel, MD
Louisiana State University – Monroe Family Medicine Program

Mrs. Jane is a 66-year-old female whose primary care provider (PCP) is Dr. Smith. Their relation spans over 4 decades since Dr. Smith opened his practice in the community. He was the same doctor who delivered her two children as well. He was also responsible for the care of Mrs. Jane's children until they moved out of state for their education. Today, she is searching for a new provider because Dr. Smith has closed his practice and retired.

According to the US census bureau's population study, by the year 2035, approximately 78 million people will be over 65 years old, outnumbering for the first time the population of those 18 and under.

An aging population may have a greater incidence of chronic ailments, physical disabilities, mental illnesses, and other co-morbidities. While the elderly comprised the smallest population size in the year 2014, they accounted for approximately 34% of all healthcare spending that year. With the growing elderly population, this number is guaranteed to escalate, and so is the need for an adequate physician workforce.

A growing life expectancy is an outcome of a good healthcare delivery system and should be celebrated. But sustaining the growth and improving health outcomes will need a bigger workforce in the near future. However, physicians are aging along with the aging population and more than 40% of the current physician workforce is 55 years and older. In Louisiana, 30% of the physician population is over 60 years of age. The American Association of Medical Colleges (AAMC) predicts that **"the United States will see a shortage of up to 122,000 physicians by 2032 as demand for physicians continues to grow faster than supply".** The pattern of an aging patient population and an aging physician population is one of the underlying reasons for the growing physician shortage. And one question is inevitable - what will happen to the growing healthcare need of our patients?

Mrs. Jane suffers from hypertension, uncontrolled diabetes, coronary artery disease, and chronic renal failure. She recently underwent a pacemaker placement for her heart problems and follows with her cardiologist every 6 months. In between, Dr. Smith managed her medical needs. Recently, she started to have worsening of her renal failure but her next appointment with a nephrologist is in 8 months who is 90 miles away. Dr. Smith would understand her problems and would do his best to help. Mrs. Jane has not been able to obtain her medical refills since Dr. Smith left. She is disheartened and is struggling to find a physician with the same skillsets who could take care of her needs.

As a family medicine resident practicing in Northeast Louisiana, the impact of physician workforce shortage, increasing demands for primary care workforce and need for a good PCP in order to address and identify health care needs is all too real. Specialist appointments booked for 6 months in advance, patients having to drive for hundreds of miles for a simple outpatient procedure and delay of care due to lack of providers are some of the stories of all underserved communities. **Louisiana suffers not only from physician shortage but also maldistribution of primary care physicians.** We have about 71 medically underserved areas and 77.3% of the state's population live in a health professional shortage area. The burden of the current shortage of workforce falls primarily on the existing providers. This increase in workload can result in physician burnout. In relation to the aging physicians, the current changes in health care systems including decreasing compensation, rising overheads, an increased burden of regulatory compliance and the complexities of electronic medical records (EMR), many physicians surveyed by AAMC indicated a fast-tracked plan to retire early. Poor job satisfaction and low morale have also led to physicians modifying their practice styles in ways that reduce patient access or leaving the practice of medicine altogether.

The most common causes of death in the US are diseases like cancers, heart conditions, and strokes. Many of these conditions may be averted at the level of primary care provider with scheduled check-ups, surveillance and early detection. Data suggests increasing 10 PCPs per 100,000 population increases the life expectancy by more than 51 days. However, not enough is being invested to create adequate positions in residency training programs to help replace the retiring physicians. This has led to a shortage of primary care physicians in the fields of family medicine, internal medicine, pediatrics, OBGYN, and psychiatry.

Evidence indicates that physicians are more likely to stay in states where they complete their residency. There are 10 family medicine residency programs in Louisiana. Of the 451 residents who completed their training between 2011-2017 in these programs, 306 stayed back in-state. Although, the solution to tackle this problem needs a multidisciplinary approach, increasing the number of residency positions and creating incentives to attract physicians to rural and underserved communities may be a short-term solution.

YOUNG IN CAREER PHYSICIAN

TECHNOLOGY: NOT REALLY SO BAD

Paul Murphy, MD
Affinity Urology Clinic

In 2050, there will be an estimated 88.5 million Americans over the age of 65. Compare that to the 40.2 million there were in 2010. Increased longevity is the product of positive changes in our healthcare society, but will there be enough skilled healthcare practitioners to keep up with the changes?

Even in the short time I have been involved in medicine, it has changed. LSU Health Sciences Center changed over from paper hospital charts during my second year of clinical rotations, sparking ire from nearly all the residents at the time. We were educated on the most cutting edge genomics, now already out of date. But the real challenge we are to face, the real threat we will have to overcome, is the gradual loss of the physicians who learned the Art of Medicine before all this technology came along.

Computed Tomography has certainly improved medicine and changed how we diagnose, treat, and monitor disease. Before CT, physical exam skills were paramount. When was the last time we wrote increased vocal fremitus in our charts (assuming it was not auto-populated when we clicked "All Normal" on the physical exam)? Scrotal swelling gets an automatic scrotal ultrasound order when often transillumination would provide the same information. I trained in a time where all of this technology was at our fingertips, and we did not have to rely as heavily on our exam. **The years of wisdom and experience in those who trained before me will one day be lost, and we cannot ever replace that.** That generation of physicians is aging. Those taking their places will be us who have always had the luxury of a CT to help us clarify the diagnostic dilemma.

The numbers are troubling, too. About 300 Urologists are trained every year, but there is exponential growth in the aging population. The retiring Urologists will add to the shortage. The balance between increasing residency slots and quality training of each physician is a delicate one. Duty hours are restricted. Resident surgeon independence in the operating room during training is nearly a thing of the past. New physicians and especially surgeons are forced to choose between taking on challenging cases, sick patients, and managing complications or the safer route of referring them out of our community to a big academic center. With the specter of a Medicare grading system for physicians around the corner which could affect our reimbursement, why not choose the safer option? **Boldness in medicine is sometimes rewarded with litigation.**

Increasing the number of quality new physicians is mandatory. Removing the duty hour restrictions or letting a resident surgeon cowboy their way through a laparotomy is not the solution to our problem. The answer may be that private physicians will have to have more stake in the game and reduce their efficiency by having a resident with them one on one. After all, academic institutions only have so much funding and so many spots. Perhaps more integration of academia and private practice would benefit both the trainer and the trainee and allow more good doctors to hang up their shingle.

But here is some good news. **This technology does make our job not just easier, but better.** We can compare new imaging to old by glancing at our screens. We have robotic surgical systems that help us operate. We have improved outcomes, less pain, fewer complications, and importantly better control of disease with some of the advances in treatments. **Those advancements were built on the research and experience of the aging physician, the ones who went before to blaze our trails.** As Sir Isaac Newton said, "If I have seen further than others, it is by standing upon the shoulders of giants."

So the way forward is, not surprisingly, like it always has been: seek out and treasure the pearls of knowledge that can be gleaned from our veteran physicians. Preserve the traditions of medicine. Call your own consults. Perform a thorough physical exam. Diligently pursue the unexplained lab finding or abnormality in your patient. Pass on your knowledge to those who trained after you. **Work hard. Love your job. We have the best occupation there is.**

PASS ON YOUR KNOWLEDGE TO THOSE WHO TRAINED AFTER YOU.

ESTABLISHED PHYSICIAN

LET'S KEEP DOING WHAT'S IMPORTANT

Michael Hayward, MD
Affinity Medical Office North

When Jennifer asked me to write this article I was dumbfounded. I didn't know why she had asked me. It's true that I graduated from medical school 35 years ago; but me, an aging physician? It took several days for me to realize and accept the appropriateness of the request.

As time passes there are changes in everything, but in the practice of medicine there have been tumultuous changes. The volume of medical knowledge needed to practice medicine has expanded dramatically. Not enough doctors are in practice now, and it may get worse. Once there were just doctors; now there are MDs, DOs, NPs, DCs, DPMs, ODs, and PAs. Electronic medical records have many uses other than patient care. The average age of the population has increased, and this increase in age is driving medical services utilization further.

THE KNOWLEDGE EXPLOSION

There is more information than any one physician can know. The depth of the knowledge of medicine has always been growing. In our education, we were told that we didn't have to know everything. What we needed to know was where to find information- usually in textbooks. Today's world is in the Information Age-when we download amazing amounts of information from the Internet at lightspeed.

Certainly, newly trained physicians have the most up-to-date information, but they have the least experience. Doctors who are nearing the end of their careers may have the least amount of current knowledge, but they truly have near maximum experience.

DOCTORS IN SHORT SUPPLY

In the US we will be 100,000 doctors short of the projected need for 2025. Fourteen per cent of the US population is greater than 65 years of age. However, many industrialized countries have larger aging populations. For instance, Japan has 25% of its population greater than 65. The US is projected to have 19% of the population older than 65 by 2030. To offset this trend, we fortunately have in our community the College of Nursing which annually trains RNs and nurse practitioners. In addition, we have the medical school under construction at ULM which will add approximately an additional 150 physicians per year beginning in 2025.

AGE AS A UTILIZATION DRIVER

Although the ratio of physicians to population have grown, a deficit still exists and is likely to worsen. This may be partially due to an aging baby boomer generation which requires more medical care for increasingly older patients.

Some estimate that 80-year-old women go for medical advice twice as many times as their 30-year-old counterparts. Eighty year-old men are estimated to go four times as often as their 30-year-old counterparts. Using this example shows that as the proportion of older patients increases, so does the need for more providers.

AGING PHYSICIAN WORK FORCE

About half of the United States' practicing physicians is older than 50 years of age. With an increasing population age and with more physicians retiring earlier, the deficit may be even greater. Many believe that electronic health records escalate the burnout rate of older physicians.

Since the vast majority of these physicians did not have computers or electronic health records in their training programs, this is often a frustrating experience for older physicians as the focus in patient care has shifted to the computer and data entry. Online medical records are being used by the legal profession, the insurance industry, and the government. As a result, those records are being modified by those institutions. Many of these modifications are not necessary for physicians or nurses to provide optimal and efficient healthcare.

I maintain that we retain our focus on patient care. We are motivated by a relationship with our patients, not a relationship with our computers. Medical records were created for a very specific purpose. In prior years, the medical record was meant to be pertinent to medical care. It was for nurses and doctors. Now our medical records are used for billing, quality of care and incentives, defense of malpractice claims, government funding, and penalties.

Even so, providers need to keep the main goal of practicing medical care as the center of their focus. **We need to keep caring for patients as the prime objective, and if electronic health records can help us do so, then so be it.** But no one can do everything all the time, so let us keep doing what is most important. Let us not give into the compulsion that enslaves us to electronic medical records which steals time we need for patient care.

A Census of Actively License Physicians in the United States, 2016

1. Physician supply strives to adapt to increasing health care demands as the nation's population ages and evolves
2. United States first-year medical school enrollment has increased by 28% since 2002
3. In 2016, 88,304 medical students were enrolled, compared to 81,934 medical students in 2012. The FSMB's prior and current census reports, between 20105 and 2016, reflect an increase of 12% in the number of physicians licensed to practice medicine throughout the country
4. There are more allopathic and osteopathic medical schools and medical students overall in 2016 than in 2010 but limits on funded graduate medical education positions as a result of the Balanced Budget Act of 1997 are preventing many U.S. graduates from pursuing the post-graduate training necessary for medical licensure eligibility
5. While earlier projections by workforce researchers anticipated physician shortages to reach upwards of 159,300 physicians by 2025, more recent predictions suggest a still-alarming shortage between 40,800 and 104,900 physicians by 2030
6. The number of actively licensed physicians who are DOs increased by 39% between 2010-2016, compared with a 10% increase in the number of MDs

Actively Licensed Physicians in the United States and the District of Columbia, 2010 and 2016	2010		2016	
	Counts	Percentages	Counts	Percentages
Total	**850,085**	**100.0%**	**953,695**	**100.0%**
Degree				
Doctor of Medicine (MD)	789,788	92.9%	870,312	91.3%
Doctor of Osteopathic Medicine (DO)	58,329	6.9%	81,115	8.5%
Unknown	1,968	0.2%	2,268	0.2%
Age				
Less than 30	16,519	1.9%	18,023	1.9%
30-39 years	184,120	21.7%	208,799	21.9%
40-49 years	214,595	25.2%	227,953	23.9%
50-59 years	215,541	25.4%	214,422	22.5%
60-69 years	138,815	16.3%	183,870	19.3%
70+ years	75,627	8.9%	94,969	10.0%
Unknown	4,868	0.6%	5,659	0.6%
Gender				
Male	583,315	68.6%	617,186	64.7%
Female	252,861	29.7%	319,145	33.5%
Unknown	13,909	1.6%	17,364	1.8%

a. Counts for licensed physicians by medical school, age and gender have been revised and updated for 2010.
b. FSMB matched physician license data with ABMS and AOA certification data to obtain counts of physicians with an active license in the U.S. and District of Columbia who also hold one or more active specialty or subspecialty certificates from an ABMS or AOA member board. The counts included in this census may vary from counts reported by the ABMS and AOA. For example, ABMS Board Certification counts measure a broader geographic base and additional specialty related degrees. The number of certified physicians for 2010 includes only those with ABMS certifications because the FSMB did not receive AOA certification data until 2015. As with all counts and percentages in the 2016 FSMB Census, resident physician licenses were excluded when such licenses could be identified.
Source: 2016 FSMB Census of Licensed Physicians.

! **The percentage of physicians who are 60 years of age or older continues to grow — from 25% of the actively licensed physician population in 2010 to 29% in 2016.**

Current Trends in Death & Dying

Over the past few recent decades, deaths have predominantly resulted from conditions related to the heart and cancer. According to the Centers for Disease Control and Prevention (2011), the leading causes of death (in order of prevalence) in the United States were as follows:

596,577	576,691	142,943	128,932	45,591	39,518	126,438	84,974	73,831	53,826
Heart Disease	Cancer	Chronic lower respiratory diseases	Stroke (cerebrovascular diseases)	Nephritis, nephrotic syndrome, and nephrosis	Intentional self-harm (suicide)	Accidents (unintentional injuries)	Alzheimer's disease	Diabetes	Influenza and pneumonia

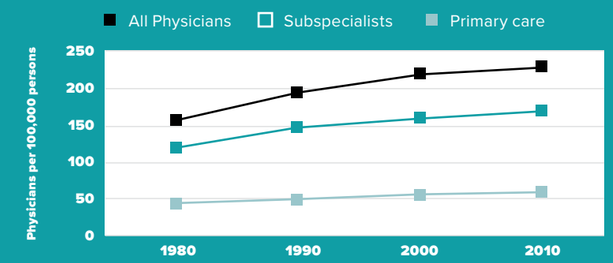
Approximately 25% of all U.S. deaths occur in the long-term care setting, and this figure is projected to rise to 40% by the year 2040.

The average life expectancy for persons in the United States is 77.5 years of age

Future projections for site of death suggest fewer than 1 in 10 people are expected to die at home by the year 2030

Trends in Physician Supply and Population Growth

Physician-to-population ratios have steadily increased every decade since 1980. The rate of growth in the physician workforce has decelerated in the past decade, but still outpaces population growth.



Information from the U.S. Department of Health and Human Services Area Resource File (1980 to 2000), American Medical Association Physician Masterfile (2000 to 2010), and the U.S. Census (1980 to 2010).

! The distribution of physicians by gender varies considerably by age categories; a greater percentage of **female physicians** tend to fall within **younger age categories** than male physicians.

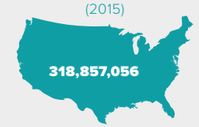
If 22% of physicians age 60+ retire in the next 1-3 years, it would result in the **loss of over 49,000 physicians** from the workforce.

About 78,000 physicians will join the workforce in the next 3 years, barely offsetting the potential number who will leave.

Because **younger physicians tend to work fewer hours** than older physicians and are more likely to take employed positions, **one new physician entering practice is unlikely to equal one older physician leaving.**

United States Population Demographics

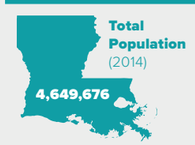
Current Population (2015)



3rd most populous country behind China and India

14.1% are age **65+**, the portion of the population that requires the most healthcare coverage

Louisiana Population Demographics



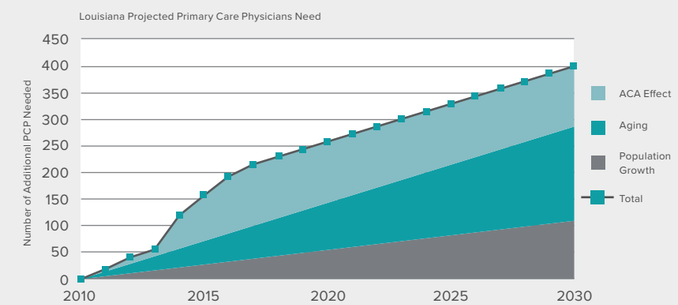
Total Population (2014)

13.3% are age **65+**

As of 2019, aproximately **11,000** people in **Ouachita Parish** are **60** or older.

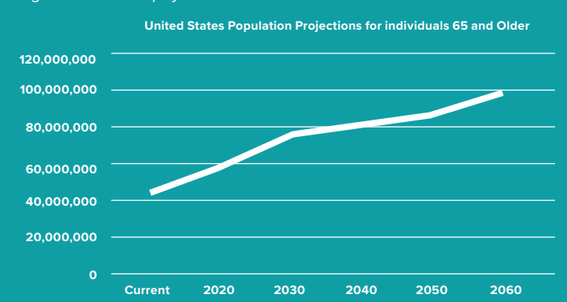
Workforce Projections 2010-2030

To maintain current rates of utilization, Louisiana will need an additional 392 primary care physicians by 2030, a 15% increase compared to the state's current (as of 2010) 2,556 PCP workforce.



The Aging Physician Workforce: A Demographic Dilemma

The doctor shortage recently was projected to reach as many as **90,400** physicians **by 2025** as patients age and as more physicians choose to retire.



Current	2020	2030	2040	2050	2060
44,958,845	56,441,000	74,107,000	82,344,000	87,996,000	98 ,164,000

While the overall physician population is aging, some specialties are aging faster than others.

Percent of Physicians 55 and Older by Specialty

Pulmonology	**73%**	Otolaryngology	**45%**
Oncology	**66%**	Anesthesiology	**44%**
Psychiatry	**59%**	Dermatology	43%
Cardiology	**54%**	Hematology/Oncology	**41%**
Orthopedic Surgery	**52%**	Internal Medicine	**40%**
Neurology	**50%**	Vascular Surgery	**40%**
General Surgery	**48%**	Family Practice	**38%**
Ophthalmology	**48%**	Obstetrics/Gynecology	**38%**
Urology	**48%**	Pediatrics	**38%**
Radiology	**47%**	Emergency Medicine	**34%**
Gastroenterrology	**45%**	Nephrology	**34%**
Neurological Surgery	**45%**		

ESTABLISHED PHYSICIAN

DOING MORE BY DOING LESS

Amy Givler, MD

When one of my patients turns 80, I shift from focusing on prevention to maintaining the status quo. After all, these octogenarians and nonagenarians have made it – they have celebrated enough birthdays to get to the goal that all those years of prevention were aiming at. They have succeeded in becoming old.

I still treat any illness that appears, of course, but I am careful to choose medications with few side effects, and I start at lower doses. With this age group, I've seen too many patients develop complications with aggressive treatments.

Unfortunately, the doctors my father goes to don't share this philosophy. My father has been older than 80 for 14 years, so he and I have a 14 year history of my gently, calmly, and diplomatically trying to monitor his medical care from 1500 miles away.

It goes something like this:

Dad: *Amy, I'm so glad to get you on the phone. I'm [insert here: short of breath, peeing all the time, having diarrhea/stomach pain/dizziness, etc.].*

Me: *I'm so sorry to hear this. Have you started any new meds lately?*

Dad: *Just the two that Dr. X started me on this week.*

Now in Dr. X's defense, my dad tends to badger doctors to address his latest symptoms until they finally prescribe something. But still, I wish Dad went to doctors with more of a minimalist philosophy. He would have an easier time of it.

And I don't want you to think that my advice is always to stop the medications he has just started. They often make sense, though the dose generally needs to be ratcheted downwards. But communicating my medical opinion is often a delicate task, and by no means are my suggestions always heeded. Quite the contrary. In Dad's eyes, I am still a daughter first and a doctor a distant second. I know he is proud of me, but there must be something about taking medical advice from a daughter that he can never quite get used to.

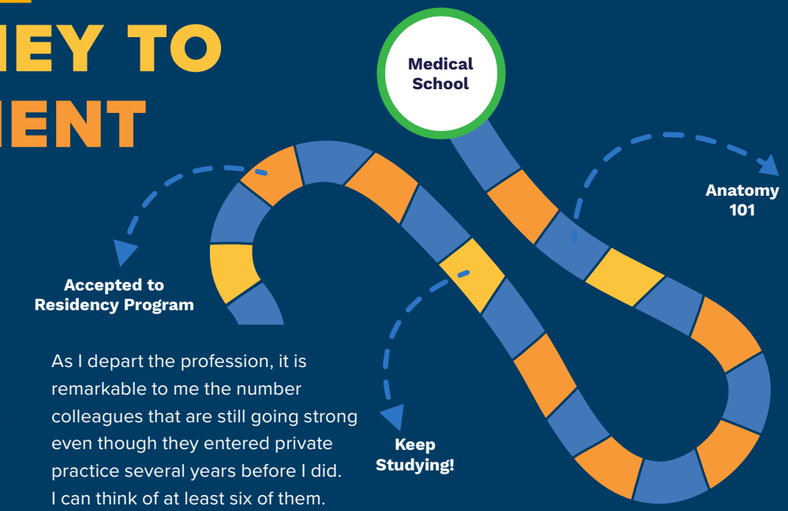
Having my father still here – and functional – is a great blessing. He has always called himself an "iron man," and indeed he has stamina even now that amazes me. But even iron men, when they pass their eighth decade, have developed some rusty spots. Sure, a vigorous scrub will remove rust from iron, but did you know a long soak in vinegar takes it off also?

For our oldest patients, less is more.

RETIRING PHYSICIAN

A JOURNEY TO RETIREMENT

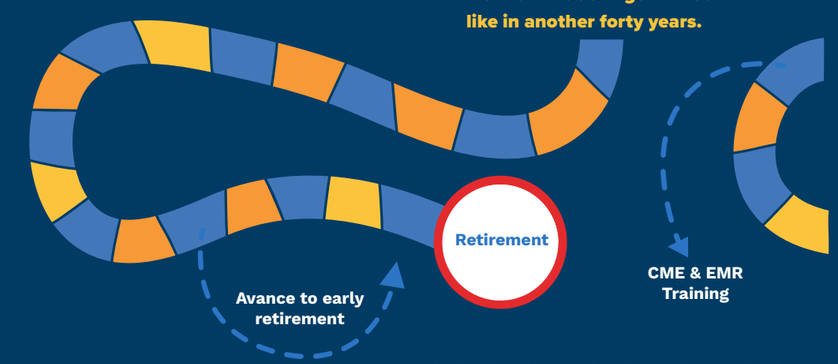
Robert S. Hendrick, Jr., MD



After 35 years in the private practice of anesthesiology, I have come to the end of the road. I have made the big decision to retire. I do so having accomplished something neither my father or grandfather (who were both physicians) accomplished – being alive and practicing medicine past the age of 62! My grandfather died suddenly while taking a nap after rounds on a Saturday afternoon. My father did retire, but only after learning he had colon cancer at the age of 57.

There is so much talk about football players and the years taken off of their lives by their chosen profession. **Not much is said about the years taken off the lives of physicians from the years of hard work and dedication, but that is the path we chose to take.** But I have digressed. I am blessed to have good health at the age of 64 and might even consider practicing longer, but family needs outweigh my desire to keep practicing.

As I depart the profession, it is remarkable to me the number colleagues that are still going strong even though they entered private practice several years before I did. I can think of at least six of them. And who can forget Richard Vines, who enjoyed helping his partners operate into his late 70s. Also, it is quite remarkable to me the advances that have been made in anesthesia and surgery during the course of my career. **The anesthesia machines that we used routinely when I started are now museum pieces.** There are two monitors we use on every anesthetic now (pulse oximeters and end tidal carbon dioxide analyzers) that had not entered clinical practice when I began my residency. They have greatly improved the safety of anesthesia. And the advances in surgery, such as robotic and laparoscopic techniques, have greatly improved the recovery of patients from major procedures. **It really makes me wonder what things will look like in another forty years.**



I am also beginning to realize how much time is needed to arrange everything for retirement. I remember a partner who retired a few years after I began practicing here. He said the first thing he was going to do was sign up for Social Security. I saw him at the IRS office four months later getting tax forms. He said after the meeting that day he might actually get his first monthly benefit check. I have to arrange converting my group health insurance to an individual policy. Then I have to follow all the steps to sign my wife and I up for Medicare. Then I have to meet with my accountant to figure out which IRA to draw from first. Then I have to roll my 401 (k) over to an IRA. Then I have to learn all the rules about minimum distributions to avoid IRS penalties. And after all of that, my wife and I are going to start in the attic and work our way down, thinning out a lifetime of accumulated knick-knacks. It wears me out thinking about it.

Looking back on it though, I have no regrets. I enjoyed my career in medicine and the benefits it brought to my patients. **Now for the next chapter....**

MEMBER SPECIALTY INDEX

Allergy and Immunology
Oyefara, Benjamin I. - MD
Zambie, Michael F. - MD

Anesthesiology
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Gates, Gordon D. - MD
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Rittelmeyer, James T. - MD
Smith, Thomas Ross - MD

Dermatology
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Smith, James Garland Jr. - MD

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Surgery, Thoracic
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Johnson, Jon Bradley - MD
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Murphy, Paul G. - MD
Rutland, Edward H. - MD

OUACHITA MEDICAL SOCIETY
MAY GENERAL MEETING

On Thursday, May 30th, members of the Ouachita Medical Society and their spouses enjoyed a summer evening at Bayou Desiard Country Club's beautiful courtyard. Kenneth E. Rhea, M.D., FASHRM spoke on Physician Care Coordination: Referrals, Consults and Transitions of Care.

Special thanks to LAMMICO for underwriting this event!

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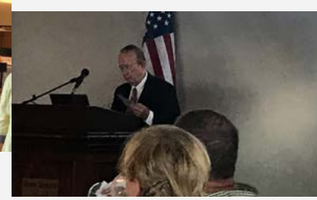

UPCOMING EVENTS

September General Meeting: State of Healthcare
Thursday, September 12th at 6:30 p.m.
Bayou Desiard Country Club

Membership Renewals:
October – December

www.ouachitams.org
for the most up-to-date information
*dates/times subject to change-check

AGING? AGING OUT? AGING POPULATION? ISN'T 65 THE NEW 45?

Cindy Bimle, M.D.

When I received the email asking me to write an article concerning this topic of 'Aging Out' and the 'Aging Population', Mrs. Mills said that she wanted the perspective from someone "well established in their career". I thought that she had mistaken me for someone else. Aging? Aging Out? Aging Population? What do any of these topics have to do with me and my pediatric career? I was initially shocked and a little offended until I stepped back and reflected on my 22 years as a pediatrician, and the fact that my oldest of my 4 daughters has joined me as a partner and realized maybe I AM aging.

Like most physicians, I have never even considered retirement or aging out and certainly not anytime soon. As I delved into this topic I started my search with the simple definition of aging out, which says "too old to remain in an age-based classification or receive age-based services". **Because of the excellent healthcare that we, as physicians, deliver, people are living longer and therefore the need for more Primary Care Physicians (PCP's) is growing.** The U. S. population is expected to increase by about 18% over the next 5 years, and the population over age 65 years will increase by 75%. Because this 'aging' population visits the doctor more often than young people, it is predicted that the workload for PCP's will increase by 29%. **As the work gets busier, when will doctors retire? Is it safe for our patients to have us work until they drag our old bodies out of the door?** After all, we are their caregivers and most doctors have spent so much time tending to their patients' needs that they have not spent much time developing a Senior Citizen hobby.

Should we have a Mandatory Retirement Age like pilots? If we are forced to retire at 65, will the already worrisome physician shortage become critical? Isn't 65 the new 45? Since 1975 the number of practicing doctors older than 65 years grew by 374%. **The baby boomers have gotten old.**

The average retirement age of practicing physicians is 66, but there are a large number of physicians practicing way beyond this age. Currently there are hospitals and insurance companies that are requiring doctors over the age of 60 to take a cognitive evaluation test before renewing their hospital privileges. The opinion of physicians on this testing is split. Most physicians are hesitant to accept this testing and offended by the thought that these institutions are requiring such restrictions. The hospitals currently requiring this testing have had positive feedback and very few physicians that agreed to the testing have failed. The current discussion among hospitals is that this will be "standard of care" for renewal of privileges. One obvious problem is the number of Primary Care doctors with active hospital privileges is declining with the utilization of hospitalist programs. The majorities of physicians do not take hospital call, admit patients, or make hospital rounds. Because of this, the specialists and hospitalists will be the ones that will fall prey to the testing since they are still rounding and admitting patients to the hospital. **Since specialists are fewer in number already, this potential restriction could again increase our physician shortage for the aging population that are requiring their services.**

So with all of this talk about aging, old age and aging out, we physicians that are considered the "well established in our career" group of doctors, need to step back and start setting a goal for retirement. There are numerous nonclinical roles that doctors can take on in their later years, or they can just decide to stop taking care of other people's needs and learn to enjoy 'old age'. I myself plan to work until my daughter kicks me out and hopefully will have enough life and energy left in me to enjoy the family foundation that my husband and I have worked so hard to build. **Again, I have NOT accepted the label of "old doctor" yet, but look forward to 65 as the new 45 era!**

Ouachita Medical Society
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