Received: 6 April 2021 | Revised: 23 May 2021 | Accepted: 15 June 2021

DOI: 10.1002/emp2.12499

JACEP OPEN | WILEY

ORIGINAL RESEARCH

Physician Wellness

The age-old question: Thematic analysis of focus groups on physician experiences of aging in emergency medicine

William Binder MD[1] | **Casey O. Abrahams BA**[2] | **Jordan M. Fox ScP**[2] | **Elizabeth Nestor MD**[1] | **Janette Baird PhD**[1]

[1] Department of Emergency Medicine, Warren Alpert Medical School, Brown University, Providence, Rhode Island, USA

[2] Warren Alpert Medical School, Brown University, Providence, Rhode Island, USA

Correspondence
Willian Binder, MD, Department of Emergency Medicine, Warren Alpert Medical School, Brown University, 55 Claverick Street, Providence, RI, 02903, USA.
Email: william_binder@brown.edu

Funding and support: By *JACEP Open* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist.

Abstract

Objectives: Emergency medicine has a demanding work environment. Characteristics influencing longevity among older physicians in emergency medicine have been the subject of ongoing discussion. The American College of Emergency Physicians (ACEP) released a policy statement in 2009 suggesting accommodating emergency physicians in preretirement years. We engaged emergency physicians to determine awareness of the ACEP policy and issues faced in preretirement years.

Methods: We conducted a series of online focus group discussions with a purposive sample of emergency physicians, age $\geq$ 50 years. The discussion guide was developed from the ACEP policy statement and relevant literature. Groups were audio recorded, transcribed, and analyzed with a thematic coding system developed iteratively by the 4-person team. Emerging themes were identified, organized, and presented with illustrative quotations.

Results: A total of 28 emergency physicians participated in 4 focus groups, with between 6 and 9 participants in each group. These physicians had between 17 and 35 years of clinical experience (median = 27), 6 were female (21%), and the majority (n = 26, 93%) worked in academic emergency medicine. Only 1 emergency physician was fully aware of the ACEP policy. Three principal content areas were identified: workload demands that change as physicians age, wellness and physician social equity, and senior emergency physician value. Interwoven across all of these was the focus on leadership and solutions to issues. Issues facing emergency physicians in their preretirement years were identified; commitment from emergency medicine site and national leadership and buy-in from junior colleagues was emphasized. Generational conflicts in recognizing the contribution and needs of preretirement emergency physicians was a major barrier to solutions.

Conclusions: Workload demands, wellness and physician social equity, and concerns about value as a senior physician are major themes confronting preretirement emergency physicians. Generational divides, deficits in local and national leadership, and

Supervising Editor: David Wampler, PhD, LP.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2021 The Authors. *JACEP Open* published by Wiley Periodicals LLC on behalf of American College of Emergency Physicians

the health detriments of rotating schedules and night shifts are barriers to longevity in emergency medicine. Further research on the value of senior physicians and the impact of hospital and departmental financial models on adopting accommodations for senior emergency physicians is needed.

KEYWORDS
aging, emergency medicine, focus group, physician perspectives, qualitative research

1 | BACKGROUND

Of the over 900,000 licensed physicians in the United States, there are 42,000 practicing emergency physicians, or about 1 physician per 7700 persons in the United States. Only internal medicine, family medicine, and pediatrics have more practicing physicians within a specialty and a lower physician-to-patient ratio.[1] Unlike the US physician workforce, emergency medicine practitioners skew toward a younger demographic. Of all practicing physicians, 15% are over 65 years, 44% of physicians are >55 years old, and in some specialties including pulmonary medicine, cardiology, neurology, and orthopedics, over 50% of physicians are older than 55 years. In contrast, only 35% of emergency physicians are older than 55 years.[1,2] This generational divide creates a unique set of challenges for the senior emergency physician.

Because of its demanding work environment, factors influencing longevity among older physicians in emergency medicine have been the subject of ongoing discussion. The American College of Emergency Physicians (ACEP) suggested that considerations should be made for accommodating emergency physicians in preretirement years.[3] Specific recommendations included shortening shifts and eliminating overnights.[3] A randomized survey of ACEP members over age 55 years supported the role of a national emergency medicine organization's endorsement of practice modifications that would promote career longevity for emergency physicians.[4] However, a survey of academic emergency medicine leaders noted that only a quarter of departments had a formal policy to accommodate aging faculty.[5]

Individual issues affecting aging in medicine have been identified previously. Debate continues to churn regarding the competency and abilities of the aging physician, as well as concerns about cognitive and physical decline. At present, mandatory retirement for physicians is not standard. Significant variability has been demonstrated in older physicians, with some retaining skill and adding value, whereas others become impaired.[6–11] A recent report described a cognitive screening program for recredentialing physicians $\geq$ 70 years that led to 13% of physicians screened leaving practice. However, in the same study, the rate of false positive screening was 57%, bringing into question the fairness and legality of such examinations to assess the cognitive ability of the senior physician.[12] "Crystalized intelligence"–the "accumulated wisdom and experience of older physicians–increases between 40 and 70 years of age, yet it appears difficult to define and measure the value of the senior physician."[13,14]

Generational differences have been identified that can have an impact on the structure, function, and culture of an emergency department. Younger emergency physicians believe that experiential learning can be offset by expanding technology, such as simulation and the acquisition of new skills including ultrasound.[15] Older physicians frequently cite circadian rhythm disruption as a barrier to successful aging in emergency medicine, and intergenerational differences regarding work-life balance and attitudes toward physiologic differences can lead to staffing friction between colleagues.[15]

1.1 | Importance

There is a paucity of literature regarding the value of senior emergency physicians to both an ED and to an institution. Additionally, although there are occasional reports elucidating barriers to emergency physicians in their preretirement years, studies examining solutions for successful aging in emergency medicine are sparse.

1.2 | Goals of this investigation

In this study we sought to identify and thematically categorize workplace issues confronted by senior emergency physicians. We endeavored to elucidate potential barriers and provide possible solutions to the issues facing senior emergency physicians as they enter preretirement years.

2 | METHODS

2.1 | Study design and discussion guide

This qualitative study design used a focus group discussion process with a purposive sample of emergency physicians. We attempted to achieve consensus opinion among the physician experts regarding issues confronting senior emergency physicians based on their responses to a series of semistructured questions.[16]

An interview guide with semi-structured questions was developed by the authors (WB, EN, JB, and is available in Appendix A). The main themes of the guide were based on the 2009 ACEP policy and research

literature, with sample questions. This was an iterative process with topics not included in the original discussion guide added after the first focus group session (Appendix B).

In reporting the study design, results, and interpretation of the results the authors have adhered to the Standards for Reporting Qualitative Research.[17]

The Bottom Line

Career longevity is a major challenge for emergency physicians. In this qualitative study of 28 emergency physicians over 50 years old, participants identified 3 major factors influencing longevity: (1) adjustment of workload to age, (2) wellness and physician social equity, and (3) senior physician value. These findings are important in the effort to support longevity in the emergency medicine workforce.

2.2 | Sampling, study setting, and population

A purposive sampling approach was used in recruiting the study participants. An email invitation was sent to emergency physicians aged ≥ 50 years working clinically in New England to attend a focus group planned to be held during the New England Research Directors meeting, a subcommittee of the Society of Academic Emergency Medicine in March 2020. This was considered likely to result in high interest for participation as many emergency physicians attend this annual event. The original intent was to hold 1 focus group at this 1-day research conference event. The invitation was sent to the clinical directors at each site asking that the invitation be distributed to eligible physicians. Because the conference was cancelled due to the SARS-CoV-2 pandemic, and there was a greater than expected interest in participating in this study, the format of the focus group was changed to 4 online meetings (hosted through Zoom) held with physicians who consented to attend. We aimed to achieve code saturation relevant to the investigation goals.[18] The institutional review board at the study site approved the study protocol, and participants received a $50 gift card for attending the group.

2.3 | Data collection and analysis

The online focus groups were audio recorded and the content of the discussions was transcribed by 2 of the authors (CA, JF). After each session the authors met and debriefed on the session and added additional questions and materials to be used in the discussion guide for subsequent sessions (see Appendix Table 1).

The content analyses, conducted after the last group was held, used the transcripts, with audio recordings available for additional information to support the data analysis. No identifying information was contained in these transcripts.

We employed an inductive approach to the thematic analyses of the focus groups' content.[19] We used this approach to identify the initial code and final themes for the content of the group. The authors (CA, JF, WB, JB) developed the initial coding structure from the group discussion guide and this was iteratively developed through the review and cross-review of the transcripts. The main themes and subthemes were developed independently by each author and then comparison and consensus agreement on the coding structure were attained before full coding of each group transcript was undertaken. The purpose of the coding structure was to identify common patterns of responses among the participants.[20] The results of the thematic analysis are presented as main themes, which were composed of barriers to successful aging and subthemes with illustrative quotes. The study protocol, discussion guide, and content analyses were developed and implemented to meet the recommended standards for qualitative research.[21]

3 | RESULTS

A total of 28 emergency physicians participated in 4 focus groups, with between 6 and 9 participants in each group. These emergency physicians had between 17 and 35 years of clinical experience (median = 27 years, interquartile range: 23, 28.5), 6 were female (21%), the majority (n = 26, 93%) worked in academic or academic affiliated institutions. All participants identified as Caucasian. Only 1 of the emergency physicians was fully aware of ACEP policy guidelines for physicians in preretirement years.

3.1 | Thematic content

In response to our interview guide, the physician groups discerned numerous factors affecting successful aging in emergency medicine. Taken together, 3 themes comprising barriers and solutions were noted and included the following: workload demands that change as physicians age, wellness and physician social equity, and the value of the senior emergency physician. Interwoven across all of these themes were underlying subthemes acknowledging generational divides between senior and younger physicians and the role of leadership in solving conflict.

3.1.1 | Effects of workload and schedules

Workload demands and the variable shift schedule were a consistent theme considered across the groups. Included in this were subthemes focusing on the physical impact of irregular shift schedules, requirements and demands to keep up with clinical skills, workplace culture, financial anxiety, as well as solutions to workload issues. Table 1 summarizes these discussions.

The majority of the senior physicians mentioned increasing difficulty with their workload, and all agreed that the overnight shifts

TABLE 1 Workload Demands

Sub-themes	Quotes
Impact of Workload and Irregular Schedules	**Patient volume** *"When I started it was not uncommon for the department to be empty at 2, 3, 4, in the morning. Now we have 15 people in the waiting room all night long. It is tougher for me to do night shifts without taking a nap."* **Physical effects** *"It's far more exhausting than when I was younger…the bouncing back from working at 2 am and coming back at 6 am."* *"It's much harder as you age for your biorhythms to swap back and forth from night today."* *"They're paying me to be quite miserable, physically and emotionally since I turned 50."*
Clinical skills	**Responsibilities** *"It's incumbent upon you as a senior provider to maintain competency, reading, sim centers; just one additional stress on top of everything else."* **New clinical practice** *"I think ultrasound is difficult for older physicians because it wasn't part of our training; we've had to learn it on our own. We are not up to par with the junior physicians who did ultrasound fellowships."*
Impact of workplace culture	**Leadership** *"There needs to be an alignment of values that translates into the strength of leadership. If you don't have all of those aligned, none of this can happen."* *"A lot of chiefs and chairs are in their forties, younger people moving up…making it harder to have as much of a voice and be understood."* **Younger colleagues** *"Years ago [my group] put [workload modifications] to a vote.…It was a very negative survey. [The attitude was] if you couldn't take nights you shouldn't be working."* *"Graduating residents are coached early not to go to an 'unfair' place (i.e., one where senior physicians are given accommodations), and this is sending the wrong message early in their career."* *"There's definitely peer pressure to keep doing nights. There's a perception within the group that once you start buying out of nights, you're not the same."*
Financial Anxiety	**Concern for job security** *"I feel like an expensive pawn. You get the feeling they'd be very happy if you leave because they can hire someone younger and cheaper that can work a certain number of hours."* **Healthcare costs** *"The number 1 reason why I think people stay on past their prime is healthcare. Most people aren't eligible for Medicare yet, and so they're going to wait until that date."*
Solutions	**National** *"What would be beneficial is if this comes from a national organization (ACEP), that way it's just a thing we support; its part of the way our specialty runs itself…it becomes less individualized based on the particular physician."* **Site level** *"Try to create a path for everyone that even young physicians would buy into, because they would be there eventually…[it] promises a lasting career that will get you to 65 no matter how old you are now…the end goal is for a long, fruitful career, right now it is not designed to be like that."* *"There was some accommodation for physicians who wanted to see lower-acuity patients where they could buy down…they wouldn't be in the trauma room on a regular basis."* **Individual** *"I've gone on and bought down my nights…for me, that has resulted in a much higher satisfaction rate, not trying to recover from 2–3 days."* **Generational** *"Therein lies the irony. Part of what senior physicians try to do is advance younger physicians' careers by trying to get them to be senior physicians many years from now. The hope is that they will love their careers and be in it at the age that [we] are now. But how do we convey it to them so they can think ahead like that?"*

had become increasingly burdensome and difficult to recover from, with advancing years. Many of the physicians noted that working overnights, along with rotating shifts, were detrimental to health because of the disruption of their circadian rhythms. Potential solutions to addressing the workload demands were discussed as is shown in Table 1. There was a consensus agreement that there must be a transparent and well-laid-out plan that the physician buys into when first starting to practice, to avoid later disgruntlement.

Security of employment was a barrier to implementing solutions across the issues raised by the physicians. Many reported that the salary differential between them and more junior colleagues not only resulted in less empathy for the issues discussed but also made them vulnerable to having to "put up with things" with the concern that younger physicians with lower salaries could replace them. One physician expressed concern that mobility in employment was also hampered by seniority, with more emphasis on income level than age

TABLE 2 Wellness and Physician Social Equity

Sub-Themes	Quotes
Parity	**Equity with other social policy advances** *"Maternity and paternity leave talks are overwhelming, but issues regarding senior physicians' needs are marginalized in favor of those issues. It is not seen as politically correct as these other issues that take priority in other industries."* *"There needs to be attention paid to wellness and the older physician the same way that we do for the younger physician and their development."*
Ageism	**Equity in Wellness** *The only discussion of wellness has been for younger people. I don't see it at all in the context of aging, but I believe this is where the wellness discussion belongs."* *"I would love to drop usage of the word "burnout". We are not talking about burnout; we are talking about different stages of life. I think that is the paradigm we need to achieve."* *Isn't wellness the right of all of us as we age?*
Solutions	**Advocacy** *"There should be parity in general benefits and in general stages of life. The focus is not on "us" unless we do have a seat at the table and bring them up as legitimate factors that are legitimate whether or not they cost money."* **Transparent process** *"There needs to be transparency. The rules that are established are the rules for everyone, not special rules for special people."* **Finding your niche at any age** *"It is every physician's responsibility to find a niche that works for them."*

concerns. This lack of employment mobility was seen to reduce any bargaining ability that senior physicians could have in advocating for workload accommodations or social equity.

Group members gave examples of strategies adopted at their clinical site to accommodate senior physicians. These included discontinuing overnight shifts at a specified age; creating a points system with differentials for overnights, day shifts, and weekends; and encouraging senior physicians to swap overnight and weekend shifts with younger colleagues. Some physicians described accommodations they had individually negotiated with their site leadership for overnight shift reductions that involved a financial cost of "buying-out" of these shifts through salary reductions. A consensus was reached that a focus on the needs of, and advocacy for, senior physicians should be spearheaded by national professional organizations.

Relatedly, the group participants raised concerns regarding leadership and workplace culture at the site level. These physicians believe that accommodations for senior physicians should not be decided by democratic vote, but instead a policy should be implemented at the executive level to become the standard of care. Many agreed that an institutional policy around accommodations for senior physicians would help to transition senior physicians to different clinical care shifts and responsibilities. It was strongly recommended that leadership enact transparent and clearly stated workload policies that provide obvious long-term benefits to younger physicians in order to increase buy-in from those younger colleagues.

3.1.2 | Wellness and physician social equity

Our physician groups suggested that wellness and social issues for senior physicians were deemphasized in comparison to their junior colleagues, and they recognized the importance of advocacy in addressing inequities. Table 2 highlights the major themes discussed.

Many participants reported that wellness and physician social equity frequently have not been considered in relation to senior physicians. Wellness is often associated with burnout and stress, and not with needs around aging. Invoking ageism, one participant remarked *"Isn't wellness the right of all of us as we age" rather than solely for younger physicians?* Another physician concluded *"I would love to drop usage of the word 'burnout.' We are not talking about burnout; we are talking about different stages of life. I think that is the paradigm we need to achieve."*

Senior physicians in the groups noted that they had argued for the value of supporting the wellness of young families and early-career physicians but now felt that their efforts were not being reciprocated. Although financial costs were appreciable in developing family leave programs, 1 senior physician remarked, "it was the right thing to do." They noted that important progress had been made on issues of family leave and childcare for younger physicians. Conversely, however, senior physicians reported no progress as they confronted family issues in regard to older children and parents.

Again, the importance of leadership in creating equity at the national and clinical site level was raised.

3.1.3 | Value of the senior physician

The value of the contributions made to the clinical practice of emergency medicine by senior physicians was discussed by all groups. The group members reflected on the contribution to the goals of their clinical site, the importance of cumulative clinical skills, and other roles assumed as a senior physician. As with other themes, solutions proffered identified the importance of leadership in recognizing and promoting the value of senior physicians. Table 3 highlights these areas.

Participants recognized the need for all physicians to contribute to the overall economic, clinical, and intellectual goals of their institutions, including a commitment to continued medical education. The

TABLE 3 Value of Senior Physicians

Subthemes	Quotes
Contributions of senior physicians	**Organizational success** *"All these people on the Zoom screen right now helped build this organization, helped it grow."* *"It's important to acknowledge the value and contribution of senior physicians to the overall strength of the group."* **Lifelong commitment to learning** *"I went half time and am aging, and I still love medicine. There are so many contributions senior physicians can make. I completely ignored ultrasound my whole career.…I just graduated a year and a half ago from my second fellowship in emergency medicine ultrasound, and that has changed my entire career path at my age.…I am not only a contributing member of my division, but I am also sought after on a daily basis by younger physicians to train them."*
Experience	**Creating clinical solutions** *Senior physicians can bring in solutions to current problems that the younger generations haven't seen. Low tech can also be important. We know about older medications and when there are shortages, we can pull in the use of traditional meds."* **Resilience and the COVID-19 pandemic** "*Reliving* [the HIV pandemic] *gave me a degree of resilience and optimism, that despite the donning/doffing and heat/anxiety, I think I can cope much better than the younger physicians."*
Other roles	**Mentorship** *Mentoring. Some of the years right after training are even harder than the training…… Mentoring that early post-training period is something we can offer to the junior faculty."* *"Gen X in particular appreciates mentoring and feedback."* **Administrative responsibilities** "*I find that I'm often asked to be on committees, take on complex questions, serving a lot of roles that don't actually have titles but need some sort of experience and perspective behind them. I find that I'm asked those more than junior faculty but it's not reflected in any sort of division or anything."*
Measuring Senior Physician	**Emphasis on clinical output** "*Maybe you can't make the same clinical contributions, but my department wouldn't be where it is without their* [senior physicians] *educational and scholarly contributions."* **Performance metrics to assess contributions of senior physicians** *"Worth seems to be assessed based on profit you generate."* **Ageism** "*Senior physicians (in my experience) where I have worked are classified as either bitter, cannot contribute with anything, not part of new-wave of our department, OR they've done it before and they were not successful so we can put them aside."*
Solutions	**Changing the culture** "*A program to care for the aging physician to change the culture of the younger generation.…eventually they will be in that position themselves."* *"Broaden view of value to include non-clinical contributions."* **Leadership** *I think it takes a strong leader to say 'I want my experienced physicians to move their careers along for the benefit of the department.'"* *"Try to create a path for everyone that even young physicians would buy into, because they will be there eventually…(we all want) a lasting career that will get you to 65 no matter how old you are now…the end goal is for a long, fruitful career, right now it is not designed to be like that."*

physicians reflected upon the substantial contributions to their respective EDs, but most of these physicians felt a lack of appreciation for their longstanding involvement. Although the physicians in the group recognized younger physicians were often able to see patients quickly (thereby generating higher relative value units), they countered that the reputation of their facilities was based on factors including quality (not quantity) of clinical interactions, as well as educational and scholarly contributions. Many of the physicians queried felt they connected better with patients than their junior colleagues. Importantly, the focus group members felt that resilience generated from previous public health crises had prepared them to better weather the current COVID-19 pandemic than younger colleagues.

Outside of clinical work, our senior physicians provided mentorship and training of both residents and junior colleagues, supporting younger colleagues during the very stressful time of career development after residency. Our participants reported that frequently mentoring was offered without reduction in clinical hours or other remuneration. Senior physicians also performed untitled administrative and academic tasks within their department without compensation. The need for performance metrics to incorporate the non-clinical

contributions senior physicians made to their departments was a consistent theme across all of these groups.

Language around senior physicians was also examined. One physician stated that the term “older” leads to discrimination and ageism, as it offers a rationale by which other departmental members can diminish or marginalize the contributions of the senior physicians.

Several of the physicians in the focus groups practiced at community or academic-affiliated sites. Under current models of staffing, community-based physicians have limited opportunity for altering workload demands in exchange for administrative roles, and issues surrounding wellness and equity for this subset of physicians were noted to be substantially different and mostly neglected. Solutions to this dilemma were not proposed.

3.2 | Limitations

Although the number of participants contributing to the focus groups was sufficient to identify the main themes, we recognize that it was a small indicator of the larger body of emergency physicians. The sample was not randomly selected, was potentially biased by physicians interested in the topic, and may not represent all possible experiences and reflections of the population of interest. Additionally, our group was dominated by physicians working in academic centers and in the New England area. Solutions to workload issues may require recasting of the economic and staffing models for community hospitals and hospitals from other regions and countries. Finally, the lack of diversity among the physicians taking part in our focus groups limited the discussion regarding the intersection of issues faced by senior physicians with other areas of discrimination owing to race, ethnicity, or sexual orientation.

4 | DISCUSSION

The results of the focus groups revealed several main themes and subthemes examining barriers to successful aging in emergency medicine. Discussions surrounding workload, wellness, and equity for senior physicians generated a lively conversation about night shifts, deteriorating clinical skills, attitudes of younger physicians, financial anxiety, and leadership's role and responsibilities toward aging staff. The thematic analysis on the value of experience and the senior physician's contribution to an ED offered insights into existential questions senior emergency physicians consider in their preretirement years.

Workload for the aging emergency physician has long been recognized as a potential impediment to a sustained career in emergency medicine. Night shifts and rotating schedules have been the bane of mid- and late-career emergency physicians. Several physicians noted that circadian harmony had changed during their career, and our participants echoed previous concerns regarding exhaustion and an inability to bounce back from overnight work.[22] Despite guidelines published by ACEP in 2009, and reaffirmed in 2015, no consistent policy toward the damage inflicted by shift work was apparent.

Workload was further affected by attitudes of younger physicians toward staffing. As 1 physician noted, younger physicians had the attitude that if you could not handle nights, you should not be working. Indeed, 1 senior physician reported that residents were coached not to work at a facility that provides accommodations toward older physicians, as this could result in being taken advantage of by a mature department.

The generational divide between younger and senior physicians is often reflected in the approach local departmental leadership takes toward senior physicians. Some groups have a culture in which senior physicians are offered a reduction in night shifts while still maintaining full-time status.[6,23,24] However, this often requires a well-staffed academic department with a top down (chairperson) approach toward scheduling. Community groups with lean staffing are often unable to comply with ACEP's guidelines regarding scheduling, and night shifts continue to be a contributing factor toward premature retirement.[22]

In response to longer lifespans and perturbations in markets, physicians retire at a later age.[25] This has left some emergency physicians feeling financially and emotionally vulnerable to workload demands. As several of our physician participants noted, in departments with younger leadership, senior physicians fear being “let go.” Shanafelt et al. affirm this notion but create an economic argument for physician retention, stating that costs associated with turnover, onboarding, lost revenue, loss of mentorship, and optimizing efficiency are profound. This is typically a blind spot in most academic medical centers.[26]

Wellness and equity were recognized by our participants as an important theme in preretirement years. Promotion of wellness has been considered an antidote to physician burnout, which is recognized to be widespread among US physicians.[27] About 50% of all US physicians display symptoms of burnout, ≈70% of US emergency physicians report a degree of burnout, and, in 1 study of emergency physicians, nearly half of survey respondents intended to retire early.[28–30] Numerous factors have been cited as a cause for burnout in emergency physicians, including modifiable ED factors, such as overcrowding, workplace violence, scheduling, and leadership issues.[23,31]

Although burnout is increasingly noted to be a systems-level issue rather than an individual problem, promoting physician well-being often is considered at an individual and small group level.[24,32] ACEP's wellness handbook, for example, casts responsibility onto the individual physician, noting that aging physicians have a choice to live a healthy lifestyle in order to last longer in emergency medicine.[33] Most organizations that do endeavor to create a systems response to burnout and wellness are unable to move past a beginner or novice phase in which individual interventions are promoted, and systemwide interventions are at best discussed but not implemented.[26] Most wellness interventions center around resident hour restrictions and programs promoting mindfulness, stress management, and other individual efforts for younger and early career physicians.[29] Our participating physicians recognized that wellness and burnout have been framed as a discussion for residents and early career physicians who face complex issues in balancing work with childcare responsibilities. A lack of parity and ageism has marginalized wellness discussions for

senior physicians; instead, these conversations often are centered around competency and retirement rather than extending careers.[6,34]

The final theme addressed by our focus groups examined the value of senior physicians. Whereas some studies suggest that outcomes in elderly patients treated by younger physicians are worse and result in a higher mortality, other research notes the positive impact of seniority on clinical efficiency, resource use, patient outcomes, and disposition in EDs.[10,33,35–37] In a commentary examining the accuracy of age-based competency screening programs, Armstrong noted that such programs "fail to recognize the value of the accumulated wisdom and experience of older physicians."[14]

Our group reported noting a feeling of underappreciation from younger colleagues and leadership. This has been echoed in other venues. In a recent discussion of aging in medicine, 1 physician reported that in his early 60s he felt increasingly irrelevant. "I began to notice that my opinions expressed in morbidity and mortality meetings, journal club, and policy meetings were politely tolerated then dismissed by my younger colleagues."[39] Although data are scant regarding the value of experience and seniority in the canon of medicine, and in particular, emergency medicine, there is no question that senior physicians can offer mentorship to younger physicians, exhibit resilience, and provide a broad perspective regarding clinical care. Our group suggested that institutions and administrators broaden their views of successful metrics and pay credence to "citizenship" for senior physicians.[15]

Our pilot study provides insights into the issues facing senior physicians in emergency medicine. Workload demands, wellness and physician social equity, and concerns about value as a senior physician were described as major themes. Future directions for research include the role and type of leadership needed to mitigate the consequences of aging and increase the longevity of emergency physicians.[40] Research using a phenomenographic approach may also provide fresh insights into the value of senior physicians.[41] Further examination of the impact of hospital and departmental financial models on staffing in academic, academic-affiliated, and community hospitals may provide additional insight into solutions to the age-old question of how to age in emergency medicine.

CONFLICT OF INTEREST

The authors have no conflict of interest.

AUTHOR CONTRIBUTIONS

WB and EN were responsible for the design of the study. JB conducted the discussion groups. CA and JF provided the transcripts of the discussion groups. WB, JB, CA, and JF conducted the analyses of the discussion groups. WB, JB, CA, JF, and EN contributed to writing and editing of the manuscript. CA and JF are equal second authors.

REFERENCES

1. Association of American Medical Colleges. 2018 Physician Specialty Data Report. 2018. http://aamc.org/system/files/reports/1/2018-aamc-physician-specialty-data-report.pdf
2. Young A, Chaudhry HJ, Pei X, et al. A census of actively licensed physicians in the United States, 2016. *J of Med Regulation*. 2017;103(2):7-21.
3. American College of Emergency Physicians. Considerations for Emergency Physicians in Pre-Retirement Years. ACEP Policy Statement. https://www.acep.org/patient-care/policy-statements/considerations-for-emergency-physicians-in-pre-retirement-years. 2021.
4. Goldberg R, Thomas H, Penner L. Issues of concern to emergency physicians in pre-retirement years: a survey. *J Emerg Med*. 2011;40(6):706-713.
5. Takakuwa KM, Biros MH, Ruddy RM, Fitzgeral M, Shofer FS. A national survey of academic emergency medicine leaders on the physician workforce and institutional workforce and aging policies. *Acad Med*. 2013;88(2):269-275.
6. Dellinger EP, Pellegrini CA, Gallagher TH. The aging physician and the medical profession: a review. *JAMA Surg*. 2017;152(10):967-971.
7. Hartz AJ, Kuhn EM, Pulido J. Prestige of training programs and experience of bypass surgeons as factors in adjusted patient mortality rates. *Med Care*. 1999;37(1):93-103.
8. Neumayer LA, Gawande AA, Wang J, et al. Proficiency of surgeons in inguinal hernia repair: effect of experience and age. *Ann Surg*. 2005;242(3):344-352.
9. Epstein AJ, Srinivas SK, Nicholson S, Herrin J, Asch DA. Association between physicians' experience after training and maternal obstetrical outcomes: cohort study. *BMJ*. 2013;346:f1596.
10. Tsugawa Y, Newhouse JP, Zaslavsky AM, Blumenthal DM, Jena AB. Physician age and outcomes in elderly patients in hospital in the US: observational study. *BMJ*. 2017;357:j1797.
11. Waljee JF, Greenfield LJ, Dimick JB, Birkmeyer JD. Surgeon age and operative mortality in the United States. *Ann Surg*. 2006;244(3):353-362.
12. Cooney L, Balcezak T. Cognitive testing of older clinicians prior to recredentialing. *JAMA*. 2020;323(2):179-180.
13. Saver JL. Best practices in assessing aging physicians for professional competency. *JAMA*. 2020;323(2):127-129.
14. Armstrong KA, Reynolds EE. Opportunities and challenges in valuing and evaluating aging physicians. *JAMA*. 2020;323(2):125-126.
15. Mohr NM, Smith-Coggins R, Larrabee H, et al. Generational influences in Academic Emergency Medicine: structure, function and culture (Part II). *Acad Emerge Med*. 2011;18(2):200-207.
16. Powell C. The Delphi technique: myths and realities. *J Adv Nurs*. 2003;41(4):376-382.
17. O'Brien BC, Harris IB, Beckman TJ, et al. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-1251.
18. Hennink MM, Kaiser BN, Weber MB. What influences saturation? Estimating sample size in focus group research. *Qual Health Res*. 2019;29(10):1483-1496.
19. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Evaluat*. 2006;27(2):237-246.
20. Saldaña J. *The Coding Manual for Qualitative Researchers*. Los Angeles: Sage; 2013. ISBN-13: 9781847875495.
21. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349-357.
22. Smith-Coggins R, Broderick KB, Marco CA. Night shifts in emergency medicine: the American Board of Emergency Medicine longitudinal study of emergency physicians. *J Emerg Med*. 2014;47(3):372-378.
23. Wong M, Chung AS. Strategies for provider well being in the emergency department. *Emerg Med Clin North Am*. 2020;38(3):729-738.
24. Sanchez LD, Wolfe RE. Physician well-being. *emergency medical clinics of North America*. 2020;38(3):297-310.
25. Silver MP, Hamilton AD, Biswas A, et al. A systematic review of physician retirement planning. *Hum Resour Health*. 2016;14:67. https://doi.org/10.1186/s12960-016-0166-z
26. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med*. 2017;177(12):1826-1832.

27. Rotenstein LS, Torre M, Ramos MA, et al. Prevalence of burnout among physicians: a systematic review. *JAMA*. 2018;320(11):1131-1150.
28. Bragard I, Dupuis G, Fleet R. Quality of work life, burnout, and stress in emergency department physicians. *Eur J Emerg Med*. 2015;22(4):227-234.
29. Yates SW. *Physician stress and burnout American Journal of Medicine*. 2020;133(2):160-164.
30. Shin J, Kim YJ, Kim JK, et al. Probability of early retirement among emergency physicians. *J Preventive Med Public Health*. 2018;51(3):154-162.
31. Chang B, Gallos G, Wasson L, Edmondson D. The unique environmental influences of acute care settings on patient and physician well-being: a call to action. *J Emerg Med*. 2018;54(1):e19-e21.
32. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017;92(1):129-146.
33. Being Well in Emergency Medicine: ACEPs guide to Investing in Yourself. Ed. Manfredi RA, Huber JM, eds. *Being Well in Emergency Medicine: ACEPs guide to Investing in Yourself*. 2017. Accessed July 28, 2020.
34. Orkin FK, McGinnis SL, Forte GJ, et al. Retirement decision making and workforce implications. *Anesthesiology*. 2012;117(5):953-963.
35. Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Ann Intern Med*. 2005;142(4):260-273.
36. Hiranandani R, Mackenzie MJ, Wang D, Fung T, Lang E. Emergency physicians choose wisely when ordering plain radiographs for low back pain patients. *Cureus*. 2018;10(8):e3126.
37. Young GJ, Flaherty S, Zepeda ED, et al. Effects of physician experience, specialty training, and self-referral on inappropriate diagnostic imaging. *J Gen Int Medicine*. 2020;35(6):1661-1667.
38. Li CJ, Syue Y, Tsai TC. The impact of emergency physician seniority on clinical efficiency, emergency department resource use, patient outcomes, and disposition accuracy. *Medicine (Baltimore)*. 2016;95(6):e2706.
39. Ault A. *Physicians Feel Ageism Less Than Nurses*. Medscape; 2018. December 3. Accessed July 22, 2020.
40. Wilson S, Rixon A, Hartanto S, et al. Systematic literature review of leadership in emergency departments. *Emerg Med Australas*. 2020;32(6):935-952.
41. Barnard A, McCosker H, Gerber R. Phenomenography: a qualitative research approach for exploring understanding in health care. *Qual Health Res*. 1999;9(2):212-226.

AUTHOR BIOGRAPHY

William Binder, MD, is an Associate Professor of Emergency Medicine and Clinician Educator at Brown University in Providence, Rhode Island.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

How to cite this article: Binder W, Abrahams CO, Fox JM, Nestor E, Baird J. The age-old question: Thematic analysis of focus groups on physician experiences of aging in emergency medicine. *JACEP Open*. 2021;2:e12499. https://doi.org/10.1002/emp2.12499