Both the report and the editorial kindly avoided mentioning an explanation that did not rely upon the debilities of aging. If we assume that the 65-yr-old anesthesiologists entered training at age 25, they would have begun residency between 1953 and 1962, just before anesthesia programs began to attract the best and brightest, as they do today. Regarding recruitment into the specialty, in 1946 John Lundy noted,[3] "There was a tendency for only those physicians who were incompetent in general practice or in other branches to limit themselves to the practice of anesthesia."

Although they examine other factors, both Tessler *et al.* and Warner appear to assume that the prime factor differentiating their three groups was aging, and probably it was. But perhaps a confounding factor was that the older anesthesiologists were less competent to begin with. This might be revealed by repeating Tessler *et al.*'s study in 10 yr.

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In Reply:

We thank Haddad, Gilmour, Katz, and Eger for their interest in our article.[1]

We agree with Haddad that there is a growing body of literature looking at the quality of care delivered by older physicians.[2,3] However, our study looked at the relative risk of litigation for three different ages of anesthesiologists and did not address the quality of care delivered by anesthesiologists who either did or did not take the Maintenance of Certification Exam. As a comment, we wish to highlight, despite Haddad's assurances the literature is "replete with studies" and "abundant data" regarding "declines in both knowledge and skill in the aging physician," the most recent cited papers in all of the letters to the editor are from 2006,[4,5] and Haddad and Gilmour quote the same two papers in support of their contentions.[6,7] We think more work is essential.

Regarding Gilmour's comments, we studied the experiences of specialist anesthesiologists, as determined by each provincial billing authority, exclusively (see also the response to Eger). It is true that there is a 1-to-1 ratio between anesthesiologist and patient in Canada, unlike the practice south of the border. It remains to be determined whether the Canadian or American model leads to a higher relative risk of litigation as anesthesiologists age.

Katz raises a valid point. We had tried to explore, as best we could, confounding variables, such as the complexity level of the various interventions performed by the anesthesiologists studied. However, there were so few moderate or high complexity procedures performed by the oldest age group that we think older anesthesiologists are probably already systematically limiting their work to their "comfort zone." Still, we agree that it remains possible some of these litigations could be because of the oldest group providing anesthesia for low complexity procedures in unfamiliar contexts or populations, and we hope our study stimulates more research in this area.

Eger raises an interesting point. It is possible that some of the older anesthesiologists in our database did not receive a similar quality of anesthesia training as is available today, and that the standards of the specialty have improved since the oldest group of anesthesiologists finished their residencies. We agree that factors affecting the quality of care provided by anesthesiologists need to be further investigated.

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In Reply:

I thank the letter writers for their interest in issues related to aging anesthesiologists (Tessler *et al.*[1] and Warner[2]) and for their thoughtful comments. Gilmour and Katz provide excellent examples that support the need for additional study of this important topic.

Haddad specifically noted that the American Board of Anesthesiologists (ABA) does not require its diplomates