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PEER-REVIEW REPORT

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Reviewer's code: 02495324

Position: Peer Reviewer

Academic degree: MD

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Reviewer's Country/Territory: United States

Author's Country/Territory: Canada

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Reviewer chosen by: Ya-Juan Ma

Reviewer accepted review: 2021-01-08 11:57

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Review time: 4 Hours

Scientific quality	[ ] Grade A: Excellent [ ] Grade B: Very good [Y] Grade C: Good [ ] Grade D: Fair [ ] Grade E: Do not publish
Language quality	[Y] Grade A: Priority publishing [ ] Grade B: Minor language polishing [ ] Grade C: A great deal of language polishing [ ] Grade D: Rejection
Conclusion	[ ] Accept (High priority) [ ] Accept (General priority) [Y] Minor revision [ ] Major revision [ ] Rejection
Re-review	[ ] Yes [Y] No
Peer-reviewer statements	Peer-Review: [Y] Anonymous [ ] Onymous Conflicts-of-Interest: [ ] Yes [Y] No

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SPECIFIC COMMENTS TO AUTHORS

This is an important subject and the authors have done a reasonable job of reviewing what is available for assessing the competence of an aging surgeon. I agree that chronologic age alone is a poor marker. For that reason, a mandatory retirement age for surgeons would be both unfair and unscientific. This specific type of review of the subject has not been done before, that is, cataloging what types of programs are available. The manuscript is well written and logically organized. I do have several specific points: 1. The authors mention in both the introduction and discussion that increasing surgeon age is associated with worse outcomes. That assertion is not clear in the literature, with some studies showing worse outcomes and some showing reasonable or even better outcomes. One study showed worse outcomes only for low volume older surgeons. In general, the weight of evidence agrees with the authors assertion, but it is not as clear-cut as they indicate. Among other studies that they might review are the following: O'Neill L, Neurology 2000; Tsugawa Y, BMJ 2018; Stevens H, Ann Surg 2018; Campbell RJ, JAMA Ophthal 2018; Guidry CA, Ann Surg 2016; Moon MR, Ann ThorSurg 2020; Waljee JF, Ann Surg 2006. 2. There are more than 9 hospitals with late career practitioner policies just in the United States. I understand that the authors were only able to find those with him on line presence. Other hospitals with known policies include the following: Stanford Lifebridge (Sinai, Northwest, Carroll) University of Virginia Health System Intermountain Health University of Pennsylvania Scripps Health, San Diego Eisenhower Medical Center, Rancho Mirage Driscoll Children's Hospital Legacy Health Providence St. Joseph Health PeaceHealth Southwest Cooper University Healthcare Pittsburgh UPMC Virtua Health Main Line Health Yale New Haven Arkansas Children's Tahoe Forest Health System Banner Health University of Utah Surgery (Each Dept at U of U credentials their own house) 3. Sinai Hospital of Baltimore's aging surgeon program is not a late career practitioner program. Table 2 as

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well as the text in the manuscript are therefore wrong. I am familiar with this hospital. They do have a late career practitioner policy which applies to all practitioners over the age of 75 regardless of specialty (see Katlic MR and Coleman J. Properly Balancing Safety with Dignity (Late Career Practitioner Policy). Physician Leadership Journal 2018; 5: 34-38.). However, the aging surgeon program is completely separate and different. It is a comprehensive 2-day evaluation of a surgeon's physical and cognitive capabilities. The aging surgeon program is specifically for surgeons sent to Baltimore by their hospitals for this comprehensive assessment. To my knowledge this particular program is unique. The authors reference the Katlic paper about this program, but did not understand that it is not a late career practitioner policy but rather a discrete comprehensive program. 4. Abbreviations in the manuscript should be spelled out the first time that they are used, for example OSATS, GOALS, GEARS and more. 5. The issues that the authors address in the discussion are appropriate. The use of simulators would be wonderful but would need to be specialty specific and the specialty societies have not stepped up to build this type of program. Assessment of intraoperative videos has been studied, initially in Michigan with bariatric surgery, and was quite effective in distinguishing intraoperative skill and judgment. However, the barriers to broaden the use of this very labor-intensive process are enormous. In summary, I believe that this review is a worthwhile addition to the literature on this important subject. With a few corrections I would recommend that it be published.