# Knowing — or not knowing — when to stop: cognitive decline in ageing doctors

Robert G Adler and Conn Constantinou

> The teacher's life should have three periods, study until twenty-five, investigation until forty, profession until sixty, at which age I would have him retired on a double allowance.
>
> Sir William Osler[1]

> Modern professionalism is about both the encouragement and celebration of good practice and the protection of patients and the public from suboptimal practice.
>
> Sir Donald H Irvine[2]


## ABSTRACT

- In Victoria, almost one in six registered medical practitioners were over 60 years old in September 2006.
- Knowing when to give up practice is an important decision for most doctors and a critically difficult decision for some.
- Normal ageing is associated with some cognitive decline, although brighter, better educated individuals may be less at risk.
- Mild cognitive impairment (MCI) is associated with higher rates of Alzheimer's dementia.
- Medical practitioners with early dementia or MCI often lack the insight to accept that they are no longer able to practise safely.
- Doctors can accommodate cognitive decline by choosing to cease procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.
- Medical Boards are responsible for protecting the public from unsafe medical practice.
- There are no agreed guidelines to help Medical Boards decide what level of cognitive impairment in a doctor may put the public at risk.


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The transition from active medical practitioner to retired doctor can be summarised in the words of a 79-year-old general practitioner shortly after retiring from practice: "One minute you are a respected member of the community and the next you're a nobody". While this may seem somewhat extreme, it is supported by comments of our colleagues and several authors.[3-6] The question of timely retirement is not unique to the medical profession, but issues of public safety place a particular responsibility on medical practitioners, their colleagues and medical regulatory authorities.

A MEDLINE search of the literature, with a variety of keywords, provided little help. One may assume that many or most medical practitioners retire, more or less successfully, and never come to the attention of Medical Boards. One may also assume that those who come to the attention of Boards over their fitness to practise, health, performance or professional conduct represent only a small proportion of those who have difficulty making the decision to cease medical practice before coming to the attention of the Board through some untoward event.

The importance of work in maintaining mental health has been widely acknowledged.[7] The prospect of retirement may be daunting for doctors who feel they have few rewarding recreational or professional options to satisfy the demands of an active mind. This may be compounded by a sense of financial insecurity, whether realistic or not. The narcissistic blow of retirement, the all-consuming nature of medicine, and feelings of indispensability may be important contributing factors to the sense of loss associated with retirement for some medical practitioners. These factors may be less of a problem for the next generation of medical practitioners, many of whom appear to have a less single-minded commitment to medicine than their workaholic predecessors.

While it is no longer acceptable to insist on an age-determined retirement age, medical practitioners are often compared with commercial airline pilots who must undergo annual health and performance checks to ensure that passengers can have confidence in those who fly their aircraft. In Australia, judges are required to retire from full-time judicial duties after the age of 70 years, yet we have no similar requirements for retirement or performance assessment of medical practitioners to ensure that they remain able to practise safely.

Age-related cognitive decline may be a factor in decisions about retirement for some older medical practitioners. It has been argued that institutions should adopt explicit performance standards of behaviour and competence, and that consideration should be given to routine cognitive evaluations of older physicians.[8] In this article, we focus on the problem of cognitive decline in an ageing medical workforce and the challenges this poses for Medical Boards charged with protecting the public from unsafe medical practice.

## The Victorian context

In Victoria, the *Health Professions Registration Act 2005* (Vic) and its predecessor, the *Medical Practice Act 1994* (Vic) , permit that state's Medical Board to conduct a preliminary investigation into the ability of a registered medical practitioner or medical student to practise medicine on the grounds (i) of their physical or mental health; (ii) that they may have an incapacity; or (iii) that they are alcohol- or drug-dependent. The Health Professions Registration Act in Victoria also requires treating doctors to notify the Board if they are of the opinion that a medical practitioner has an illness or condition that may seriously impair that practitioner's ability to practise medicine and may result in the public being put at risk.

There are just over 19 000 medical practitioners registered with the Medical Practitioners Board of Victoria (MPBV), in a state with a population of about five million people. The Board's database does not identify how many of these practitioners actually practise in Victoria, how many are registered in more than one state, or how many have retired from practice but continue to maintain full registration. Some of these problems of workforce data may be rectified once the National Registration and Accreditation Scheme

**Age distribution of medical practitioners registered in Victoria at 30 September 2006**

| Age (years) | Number (% of total) | Non-practising registration* (% of age group) | Known to Health Committee† (% of age group) |
|---|---|---|---|
| All ages | 19 065 | 807 (4.2%) | 162 (0.85%) |
| 61–70 | 1874 (9.8%) | 130 (6.9%) | 18 (0.96%) |
| 71–80 | 840 (4.4%) | 138 (16.4%) | 10 (0.89%) |
| > 80 | 276 (1.4%) | 69 (25.0%) | |
| Total > 60 | 2990 (15.7%) | 337 (11.3%) | 28 (0.94%) |

* A category of registration that allows medical practitioners to remain on the register while not undertaking any clinical duties. † Committee of the Medical Practitioners Board of Victoria responsible for investigating notifications about the health of medical practitioners and monitoring their compliance with conditions imposed by the Board on their medical registration. ◆

for health professionals is introduced in July 2010. The age profile of practitioners and those known to the Health Committee of the MPBV is shown in the Box.

As one might expect, the number of registered medical practitioners in each age group over 60 years decreases with age, while the proportion in the non-practising category increases. Somewhat surprisingly, the proportion of practitioners aged over 60 years who are known to the Health Committee remains fairly constant (0.94%), and is not substantially higher than the corresponding percentage of all registered medical practitioners (0.85%). This is consistent with our experience that the reasons for notification to the Board on health grounds change with age. Younger medical practitioners are more likely to be notified to the Board because of concerns about substance misuse or psychiatric disorders, while older practitioners are more often notified because of concern about their cognitive functioning.

In recent years, there has been an increase in notifications to the MPBV Health Committee relating to possible "cognitive" and other health problems, as opposed to substance misuse or psychiatric disorders. From 1 October 2004 to 30 September 2006, "cognitive/other" notifications made up 50% of all notifications to the MPBV.

The literature on cognition and ageing is not particularly helpful when a medical registration authority is faced with the dilemma of helping medical practitioners, who may have served their communities with distinction for many years, decide it is time to cease practising to protect the public from unsafe practice. The Board's preferred approach is to counsel such medical practitioners to consider retirement rather than facing the humiliation of suspension of their medical registration followed by a formal hearing to determine their fitness to practise.

When there are concerns about a doctor's cognitive capacity and he or she refuses to retire, the doctor is usually referred for neuropsychiatric or neuropsychological assessment. Although such testing is often helpful, it has become clear that there are no agreed standards as to the level of impairment sufficient to warrant suspension or cancellation of medical registration on the grounds of fitness to practise.

## Dementia and age-related cognitive decline

There is ample evidence that some cognitive decline is a function of normal ageing, even though there is considerable variation between individuals.[9,10] This ageing process particularly affects cognitive speed and short-term memory, as well as the so-called fluid abilities ("those cognitive faculties involved in the solution of any new type of problem").[11] With increasing age, there is also greater variability of performance on tests of cognitive functioning. By contrast, crystallised intelligence ("the cumulative end product of information acquired"[11]) is usually preserved until well into old age. The difficulty a doctor experiences may be compounded by hearing or visual impairment and decline in manual dexterity.[12] Clinical decision making requires a combination of new problem solving (fluid intelligence) as well as clinical wisdom (crystallised intelligence).

There is preferential shrinking of the frontal lobes with age, but the correlation with cognitive decline is poor. It has been suggested that the frontal lobes, phylogenetically the last to mature, may be the first to deteriorate with age or disease.[10] The frontal lobes are associated with the exercise of judgement and insight, functions that are frequently impaired in early dementia. This may be particularly relevant to the difficulty some medical practitioners have in accepting that they need to cease medical practice.

There is a growing body of evidence to suggest that brighter, better educated individuals may be at lower risk of age-related cognitive decline and possibly even Alzheimer's dementia. When assessing highly intelligent older individuals, one may need to adjust for premorbid intelligence, because a result in the average range using age-adjusted norms may represent a significant decline in their intelligence.[13] Mild cognitive impairment (MCI) is characterised by memory complaints in non-demented, healthy older persons. Those with MCI progress to Alzheimer's dementia at the rate of 10%–15% per annum, compared with 1%–2% among controls.

The practical problem facing Medical Boards is that medical practitioners with early dementia or MCI often lack insight into their deficiencies and may be reluctant to accept that they are no longer able to practise safely. We have found it is often helpful to involve trusted family members, partners or children when dealing with a doctor who shows evidence of declining cognitive function and is reluctant to consider a timely, dignified exit from medical practice. In some cases there is almost a sense of relief that someone is taking control of the situation. However, we have also encountered family members who cannot accept that their loved parent or partner is no longer fit to practise, in which case the Board may be forced to conduct an investigation into the doctor's health and fitness to practise.

## Cognition and safe medical practice: the practitioner's perspective

There are a number of things medical practitioners can do to accommodate the changes described above. Many procedural specialists choose to cease procedural work or are forced to do so when their credentials are not renewed. The relative lack of regulation in the private sector has sometimes meant that practitioners who are prevented from operating on public patients can continue to operate on private patients.

Older practitioners can adjust to some of the changes in cognitive functioning by allocating more time to each patient, by using memory aids, by working with others to whom they can turn for advice, and by seeking second opinions on difficult patients more readily than they did when they were younger. Clinical wisdom is likely to stand the practitioner in good stead

with routine problems, but unusual or unexpected problems are more likely to cause difficulty for older practitioners.

## Cognition and safe medical practice: the medical regulator's perspective

The primary purpose of Medical Boards is to protect the public by ensuring that those who practise medicine are able to do so safely. Our experience suggests that professional practitioners are generally reluctant to notify the Board of concerns about a colleague's declining cognitive functioning. Most notifications to the Health Committee about older doctors are made by treating doctors and occasionally by concerned or disgruntled patients.

Historically, competence to practise has been judged by one's peers, and this is still the approach used when a medical practitioner's performance is being assessed. Of considerable concern is the Canadian finding that 26% of physicians (7/27) undergoing a Physician Review Program in 1997 showed moderate or severe cognitive difficulty.[14] This raises questions about the level at which cognitive difficulty becomes incompatible with safe clinical practice. The lack of evidence-based criteria makes decision making very difficult for Medical Boards if it is the case that age-adjusted norms may not detect significant cognitive decline in highly intelligent individuals.[13]

Compulsory continuing professional development and recertification seem inevitable; the question is not whether this will happen, but when and how. Models for revalidation and relicensing are being introduced in the United States, Canada and the United Kingdom. In the UK, recertification will involve revalidation based on "evaluation of a doctor's medical work against *Good Medical Practice*" as well as specialist recertification.[15] Older doctors have apparently been prominent among those expressing concerns, but have had to accept the changes. The challenge is to ensure that such changes are effective without becoming unduly bureaucratic and onerous. A preventive approach to safe medical practice and continuing medical registration has been proposed.[16]

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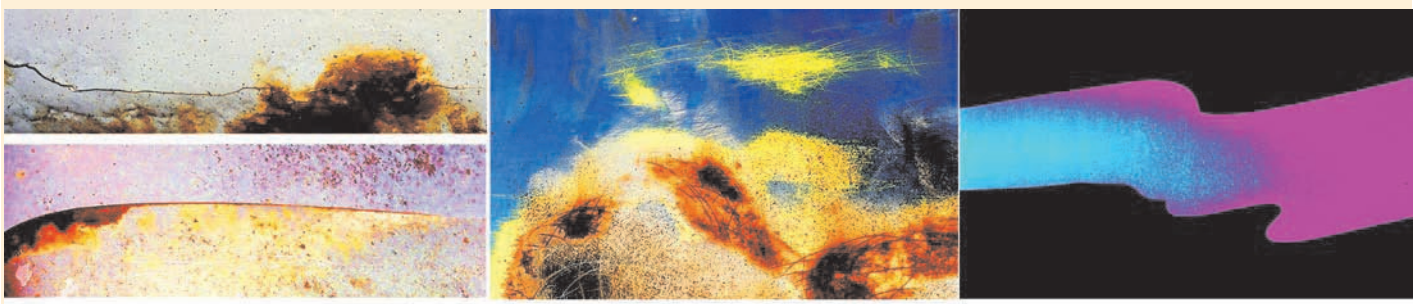

**Untitled.** Photographs. Close-up views of parts of rusting car bodies. **Dr Graeme Choat**, GP, Thornton, NSW.