MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 10 JUNE 2015 AT 6.15 P.M.

THE TOPIC: AGEING IN THE PROFESSIONS

SPEAKER: DR CHANAKA WIJERATNE

DR MICHAEL DIAMOND: Welcome everybody on this wet, wintry evening. We have a cracker of an evening, of real interest I would imagine to all of you who have turned up and perhaps many who might have forgotten. However I will refrain from making any more jokes.

What we have this evening is a product of our committee discussions where the issue of the ageing professional practitioner comes up in various ways, both medically and legally. We are very fortunate and blessed to have two speakers this evening who are very relevantly skilled in looking at the sorts of issues that are of interest to all of us.

Our first speaker tonight is Dr Chanaka Wijeratne. I have read many of his expert reports over a number of years and it was my pleasure to meet him this evening for the first time. Dr Wijeratne is going to speak on his area of interest and specialty and particularly, the role he performs in the assessment of medical practitioners who may have the associated effects of ageing and impairment. Dr Wijeratne is a psychiatric colleague. He was educated at Sydney Grammar School and graduated in medicine from the University of NSW. He is a senior specialist in the academic department of age care psychiatry, Prince of Wales Hospital specialising in mood disorders and neuro-degenerative diseases. Dr Wijeratne also works in the private sector. He is former board member of Capacity Australia, with a special interest in testamentary capacity assessment. This would be of interest to our lawyers present tonight. His interest in the health of medical practitioners developed through his work as a consultant to the health program of the Medical Council of NSW.

As an aside, given the ageing medical workforce, those of us who work with the Medical Council, are frequently challenged by issues that are difficult and subtle in dealing with ageing practitioners. The questions that arise, both from the public protection aspect about their capacity and safety to practise and from the needs of the practitioners, are very difficult to balance. We rely heavily on the work of Dr Wijeratne in providing very clear, descriptive expert assessments in that regard.

Without further ado, Dr Wijeratne

DR CHANAKA WIJERATNE: Thank you Michael. Before I begin, I want to thank Georgie Haysom for this kind invitation. I should also say that tonight my talk will

focus on doctors because that is my area of my clinical experience, as Michael has just said, and my area of academic knowledge. However my remarks today are likely to be equally relevant to the legal profession. In fact, I would urge the legal profession to make formal study of the areas that I will discuss.

We should start by defining what exactly we mean by ageing. Geriatric medicine and old age psychiatry services in New South Wales use 65 years as the entry point. However this is really an arbitrary cut-off. It was determined at a time when people had much poorer diets, smoked more, and worked in physically far more demanding jobs than people do nowadays. They were from a generation that had been through the Great Depression and a World War, so that if they ever got to old age, they did so in a much poorer state than the subsequent boomer generation. What this illustrates is that when we talk about ageing, the so-called cohort effect is an essential consideration. Cohort effect refers to the characteristics shared by a group of people born around the same time, exposed to the same events, and influenced by the same demographic trends. Within any cohort, the vagaries of ageing generally begin later in those of higher socio-economic status.

So the term ageing is certainly very context dependent and may even be pejorative to some. An alternative term, that I prefer, is late career practitioner (LCP). It is not a euphemism. It is clearer, it is less pejorative and much easier to define. If we take most doctors working in Australia today the vast majority achieved an undergraduate medical degree, which means that you started your career at 25 years of age, when you are an early career doctor, around 40 years of age is when you reach mid-career and about 55 years of age is when you reach late career. So 55 and older is the age range that I mean when I talk about late career practitioners.

Currently the ageing medical practitioner is essentially a male phenomenon. The distribution of male doctors is relatively even across age, with male doctors working after the age of 65 years comprising more than 10 per cent of the male medical workforce. The number of female doctors declines gradually with age, with very few working into their seventh decade. That will no doubt change in the years ahead as the majority of doctors aged under 30 are now female, which is another cohort effect as it were.

Late career practitioners have much to commend them, not least the provision of an essential public service, especially in outer metropolitan, rural and remote areas. Although I am unaware of any formal studies, the lay public's view of this group seems broadly positive. In lieu of any research in this area, I googled "100 year old doctors". I got three hits. In contrast when I typed in "100 year old lawyers" there were no hits. The oldest working lawyer was 95 from the USA. The three doctors were all from the US as well. The kinds of things that people said about them were: "… he knows everything"; "experience does count for a lot …"; and " … unending devotion to medicine". The unending devotion is about a Dr Watson no less who delivered something like 18,000 babies in his career.

More scientific research has shown that late career practitioners are valued by their junior colleagues for their wisdom (Draper 1999). The doctors themselves are at a privileged stage of their career where they are less likely to experience burnout (Peisah et al 2008). These mature doctors are now experts, esteemed for the skills which are sought after by patients, trainees and peers alike.

However there is always another side to the same coin, as was illustrated in an article published in the *New York Times in January 2011* titled "As Doctors Age, Worries About Their Ability Grow". This other side is the potential for age related changes in health to place the public at risk as Michael noted in his introductory remarks. That risk to the public is the primary criterion when we assess doctors in the health program for the Medical Council.

The question then becomes whether we could, or should all work indefinitely or could we work indefinitely. Tonight I will look at two main issues - the challenges to maintaining the capacity to practise medicine, from both an individual and systemic perspective, and importantly, how professionals and indeed, the professions themselves should respond to this challenge.

I am sure everyone here knows that capacity is not a global phenomenon but is very task specific. For example, there is a particular test to determine testamentary capacity in someone and so on, according to whatever task you are assessing. In the case of determining a doctor's capacity to practise, there is The Law, or to use its full title, the *Health Practitioner Regulation National Law* (2010). Under our current

regulations competence to practise medicine is defined on the basis of four broad criteria. They are the maintenance of sufficient physical capacity, mental capacity, knowledge and skill, and communication skills, including an adequate command of English. This rather dry and reductionistic legal definition compares with definitions written by medical educators and academic bodies which are more complex and describe other dimensions to professional competence. One seminal academic definition of competence is that it is the "… habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and the community being served." [*Epstein & Hundert (2002)*].

One problem with our legal definition is it runs the risk of professional competence being viewed as a static phenomenon that is acquired permanently, and so assumed to persist over the course of several decades of active practice unless doubt is formally cast. In contrast, academic definitions have emphasised professional competence as not only impermanent but context dependent, and developmental. This last feature of competence is especially worthy of consideration when discussing the late career practitioner.

The Health Practitioner Regulation National Law does, however, give us a convenient way to examine the challenges faced by the ageing practitioner with regard to maintaining professional competency. I will now consider each of those four main criteria.

Knowledge and Skills

The basics of competence are technical knowledge and skills. The late career practitioner has moved through various stages of career development, including the competent and proficient stages to now being expert. Given continuing medical education is a prerequisite for professional accreditation, it is inconceivable that any late career practitioner will not engage in a process of ongoing learning of their craft.

Despite that, the data is very clear. More experienced and older medical practitioners have been shown to possess less factual knowledge and to be less likely to adhere to clinical guidelines than younger and less experienced practitioners. Other studies have shown that whilst more experienced practitioners' knowledge of

static information, that is information that is still current from when they were a trainee, was as good as that of younger colleagues, their knowledge of new information, that is, information that has become current since they became specialists, was poorer.

This suggests that older practitioners retain core knowledge, but may not integrate novel information into their practice as well. On the other hand, it has been argued that the essence of competence is not just factual knowledge but the ability to tolerate and manage ambiguity, and make decisions with, at times, limited information (Schon). Expert practitioners also make greater use of tacit information (Polyani), including heuristics and pattern recognition, over explicit knowledge. One danger of intuitive practice, however, is the finding that diagnostic accuracy in doctors is greater in more experienced practitioners when only contextual information is presented, but declined if contradictory information about a case was included.

The expert clinician may make a diagnosis on intuition and personal experience, in the absence of specific confirmatory information. Given this, the challenge for the late career practitioner is to develop insight into their own clinical techniques, to consider their own cognitive and emotional biases in their clinical practice and to seek new information and methods on an ongoing basis.

Communication

I would seem self-evident that competence in communication goes well beyond an ability to speak in English, or whatever is the language of the majority population being served. The essence of communication, certainly for a doctor, is the ability to form a therapeutic relationship with patients and their carers, which incorporates an understanding of the specific culture or sub-culture in which the patients exist.

What is really important for late career practitioners, and this is an issue for a number of doctors I have assessed on behalf of the Council, is the need to keep up with major social and cultural changes over the course of their careers and to adapt their practice to varying societal expectations. A failure may lead to patient complaints.

It is important for late career practitioners to be mindful of a couple of these cultural and social challenges.

The first is the rapid growth of Australia as a multi-ethnic and socially diverse society, so that awareness of cultural differences in medical care is an essential part of competence. The late career practitioner must adapt to being a culturally versed global physician (Martimianakis) with an appreciation for diversity and a need to understand and accept a variety of perspectives (Salas-Lopez).

The other major change is medicine has moved from a more paternalistic model of care to a treatment model in which the patient is best managed by a multidisciplinary team of health professionals with diverse, but complementary, skills. Thus, communication includes the ability to work effectively with various colleagues, not only from other medical specialities but also other health disciplines, such as nursing, psychology, occupational therapy and so on, so as to provide the highest level of care available. A number of doctors who have been the subject of a notification to the Medical Council have confessed that these were not skills that were taught to them. However they are essential to be able to provide the highest level of care.

A final shift that many late career practitioners may have noticed through the course of their career are that patients are no longer uncritical recipients of their medical care. Not only is a commitment to collaborative decision making in management essential, the late career practitioners should expect their methods to be questioned by the patient and carers.

Physical Capacity

It would be reasonable to say that physical health tends to be taken for granted by medical practitioners. The mostly benign physical health enjoyed by doctors is a relatively recent phenomenon. Medicine was once a dangerous profession. Doctors, even in industrialised countries, continued to have higher mortality rates than the rest of the population well into the 20th century. It was only around the 1950s and 1960s that doctors' health overtook that of the rest of the population to be where it now sits, along with that of other professions. One obvious reason for the change is the treatment of communicable diseases. Doctors in the pre-antibiotic era

were more likely to die from infectious diseases just as radiologists were more likely to die from radiation associated diseases. The other big change has been improvement in lifestyle factors, in particular not smoking. I think even in the 1960s about three quarters of doctors smoked, so the scenes from *Mad Men* where the obstetrician smokes while examining the patient are quite true. In contrast, a survey last year (2014) showed only about two per cent of medical practitioners now smoke. This is a sharp decline in a short time.

Despite the improvement in overall health, medical practitioners are not immune from chronic disease. Some of this ongoing physical morbidity is due to self-neglect, given one in three of us do not have an independent general practitioner, the high proportion of the profession that approves of self-treatment and self-prescription, and the failure to follow our own clinical guidelines on sleep, physical exercise and various health screening programs. We should remember Osler's observation that "The physician who doctors himself has a fool for a patient".

Different medical specialties make varying demands on the physical capacity of late career practitioners. Pathologists and radiologists need to maintain exemplary vision, surgery requires stamina and steadiness of hand, and so on. Doctors are not prone to any specific diseases by dint of their occupation. Common physical diseases in the 40 o doctors that I have seen for the Medical Council include vascular risk factors (hypertension, hypercholesterolaemia, diabetes mellitus, obesity, coronary heart disease); neurological disorders (Parkinson's disease, stroke, small vessel cerebrovascular disease), other brain disease (depression and bipolar disorder, alcohol related brain damage) and sleep apnoea. Most of these disorders are not debilitating per se and they are all treatable. However each of them, either directly or indirectly increases the vulnerability to cognitive impairment. For instance, cardiovascular risk factors can cause cerebrovascular disease ("mini strokes").

Mental Capacity (psychological)

There are two potential threats to mental capacity. These are mental disorders and age related changes in cognition.

To start with mental disorders, there will be a small proportion of late career practitioners who experience chronic, relapsing conditions such as bipolar disorder. These tend to be lifelong conditions, and capacity may be temporarily impaired and regained.

When it comes to depression, the Australian National Mental Health Survey of Doctors and Medical Students, conducted by Beyond Blue in 2013 surveyed about 11,000 participants, and is by far the biggest survey of this type in the world. It included over 2000 medical practitioners aged over 60 years, which is very helpful. Preliminary data from this suggested that the rates of psychological distress, as measured by the K10 and the GHQ28 rating scales of psychological distress, and also the rates of suicidal ideation over the previous 12 months, all tended to decline with age.

In some ways, this is counterintuitive as received wisdom is that older age is a period of inevitable decline, but the findings are consistent with the results of community studies of depression across the age spectrum. Similarly, although not a mental disorder, the same trend was seen for burnout. Two particular domains of burnout, emotional exhaustion and cynicism, declined with age and were lowest in the oldest age group.

The question arises as to why this is so. One possible explanation may lie in a particular model of work related stress. This model, called "demand-control imbalance", says work stress increases as there are high situational demands on an individual practitioner, in the absence of a concomitant increase in the power to alter the situation. In other words the lack of control means a lack of power to alleviate work related stress. The lower rate of psychological distress in the late career practitioner may be the result of being more senior and therefore having more authority in their workplace. Another explanation may be that this is a survivor effect. Hence doctors who keep working to this age group are just better adjusted psychologically.

The relationship between age and alcohol abuse in the Australian National Mental Health Survey of Doctors, was different. Hazardous (moderate level) alcohol use was highest in the youngest doctors and medical students in the 18 to 30 year age group. It dropped thereafter, but plateaued across middle and old age. There was little difference in harmful (heavy) alcohol use across all the age groups. This suggests the oldest doctors who drink

in a potentially harmful manner to their health have done so for many years and are probably recidivists.

Mental Capacity (cognition)

Finally, we come to what I would describe as the most seminal challenge of ageing for the professions, that of cognitive changes with age, which Michael also alluded to in his introduction.

First there is some good news. Medical practitioners have a theoretically lower risk of developing dementia. Factors such as higher levels of education, occupational complexity and more complex lifestyle activities, each reduces the risk of dementia by around 50 per cent. But that does not mean medical practitioners are immune to cognitive impairment. The commonest diagnosis in practitioners in my experience is so-called Mild Cognitive Impairment (MCI). This refers to a syndrome in which cognitive decline is in excess of what you would expect for so-called normal ageing, but without the more severe cognitive impairment and functional decline seen in dementia. One way to look at MCI is that it is potentially a pre-dementia syndrome although not everyone with MCI will convert, as it were, to dementia. Another analogy is that MCI is the top of the slippery slope before the onset of dementia.

There are also specific age related changes in cognition that need to be considered. With advancing age there is a steady downward trend in what we call fluid intelligence. Fluid intelligence is the ability to think, reason abstractly and solve problems, especially in novel situations. This peaks in adolescence and begins to decline progressively beginning around the age of 30 or 40 years.

On the other hand, crystallized intelligence, which unlike fluid intelligence, involves knowledge that comes from prior learning, experience and education is stable or slightly better with advancing age. The big question is whether the deterioration in fluid intelligence can be compensated for by the stability or slight improvement in crystallised intelligence.

This next set of data is from an American study of 1100 doctors from Florida. It is an important study because of its size, that it included doctors across the age spectrum and that none of the doctors were the subject of an enquiry of a regulatory authority. They were mostly

practising although some had retired. The study measured five domains of cognition, attention, memory, mental calculation, reasoning and visuospatial perception, and reported a total score for cognition. There were three important findings. The first was a slow, steady decline in total cognition scores from mid-career. Many subtest scores did not change significantly up to age 65 years, however by age 75 years, average scores on almost all domains were significantly lower than those of people aged under 35 years. The second was the growing gap between the best performing and the worst performing doctors with increasing age. The domains that distinguished the best from the worst performing in the oldest age groups were attention, memory and reasoning. Thirdly the decline with age is not uniform. There is a minority of doctors over 75 years of age who are performing as well as the average (but not the best) 35 year old. Such data may help the late career practitioner determine the best time for retirement.

The Response of the Professions

What should be the response of the profession and the individual professional to the challenges that I have outlined tonight?

There should be an acceptance and acknowledgement at an institutional level. All the medical colleges need to follow the lead of the College of Intensive Care Medicine in implementing a policy statement on the needs of late career practitioners. To date, it is the only college to have done this. The College of Surgeons has an older surgeons' special interest group. Simple adaptations such as reduced after-hours shifts or on-call work and reduced exposure to acute crisis intervention can also be made. The Canadian Colleges' (CANMeds) view of the life cycle of the medical practitioner now includes a phase transitioning out of professional practice. That is another important acknowledgment of the career span of a doctor from intern to retirement.

At an individual level, there are two things to remember. One is to ensure that each professional ages well. Here the term successful ageing is appropriate. The original definition of successful ageing characterized it as freedom from disease and disability, high cognitive and physical functioning, and social and productive engagement. The term has subsequently evolved to incorporate the perspectives of older people, and subjective quality of life which is closely related to

things such as resilience, optimism, and social and community involvement, is now seen as more important than traditional measures of health.

The other personal response is to lose our fear of the 'R' word which I am not going to mention it just yet but will ease you into. I think the fear of the 'R' word is something that every single doctor I have assessed for the Council has. What we have to remember is that retirement is not a single event that is always two or three years in the future. Retirement is a process that requires planning across multiple domains, not just financial. The basic message is that if you stay psychologically healthy, wealthy, partnered and in control of your exit from work you will have a well-adjusted post retirement phase and the 'R' word will not be the ultimate challenge for the ageing professional.