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Physician don't heal thyself: a descriptive study of impaired older doctors

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ABSTRACT

Background: The growing and welcome interest in the issues leading to distress and impairment in younger doctors has not been mirrored by a focus on the similar issues in older doctors which is surprising given the aging medical workforce.

Objectives: To improve understanding of impairment in older doctors and to facilitate the planning of primary prevention strategies.

Method: Consecutive case records of notifications to the Impaired Registrants Program of the New South Wales Medical Board, Australia, of doctors over 60 years from January 2000 to January 2006 (N = 41) were examined. Details of demographics, type of practice, nature of referral, medical morbidity, cognitive examination, psychiatric diagnosis and outcome of assessment were recorded.

Results: Impaired older doctors suffered cognitive impairment (54%), substance abuse (29%) and depression (22%) and 17% had two comorbid psychiatric conditions. Twelve percent had frank dementia. Two work patterns – the "workhorse" and the "dabbler" – were observed, as was a culture of postponed retirement due to a sense of obligation and working "until you drop." Impaired older doctors were found to have higher chronic illness burden compared with community norms. Almost half were the subject of patient complaints or of poor performance within ten years of presentation.

Conclusion: To our knowledge there has been no other comprehensive examination of patterns of impairment in older doctors. Older doctors are prone to suffer "the four Ds": dementia, drugs, drink and depression. We need to encourage mature doctors to adapt to age-related changes and illness and validate their right to timely and appropriate retirement.

Key words: impairment, older, doctors, physicians, cognitive

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Introduction

As the population ages, so too does the medical workforce (AMWAC, 2005; Sessions *et al.*, 2006). While much ado is made about young doctors in crisis or our "duty of care" to students and junior doctors in distress (Confederation of Postgraduate Medical Education Councils, 2002), there appears to be a paucity of literature and policy addressing the physical and mental health needs of aging doctors. Aging doctors are no less vulnerable to mental health problems than their younger counterparts, and indeed are probably more vulnerable due to age-related somato-sensory and neurodegenerative changes (Peisah and Wilhelm, 2002). What limited study there has been of aging doctors has primarily focused on cognitive impairment (Vincent, 1979; Lunsford, 1981; Mason, 1988; Eva, 2002), while other causes of functional decline such as depression, substance abuse and medical co-morbidity have remained largely unaddressed. These disorders are well documented in younger physicians who are said to suffer from the "the three Ds" (depression, drugs and drink) (Schattner *et al.*, 2004). Younger impaired physicians (particularly those who abuse substances) are often male, working within a rural setting and frequently come from the specialties of psychiatry, anaesthetics and emergency medicine (Domenighetti *et al.*, 1991; Hughes *et al.*, 1992; Pethebridge, 2005). In contrast, the demographics of and patterns of impairment in older impaired physicians are virtually unknown.

Over the past twenty-five years or so a number of therapeutic programs have been developed specifically for doctors whose clinical abilities may be impaired because of psychiatric or physical illness. These have been developed either independently of, or affiliated with, medical regulatory bodies (Wilhelm *et al.*, 1997; Brown and Schneidman, 2004; Oxley, 2004; Puddester, 2004; Warhaft, 2004). In Australia, programs for impaired doctors fall within the jurisdiction of each state or territory medical registration authority and vary accordingly.

The Impaired Registrants Program was embodied in the Medical Practice Act 1992 in New South Wales (NSW). Physician impairment was defined as:

> "Any physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to practise medicine. Habitual drunkenness or addiction to a deleterious drug is considered to be a physical or mental disorder." (Medical Practice Act (NSW), 1992).

The NSW program was developed to deal with impaired doctors in a constructive and non-disciplinary manner, with the dual aims of protecting the public and maintaining doctors in practice wherever possible. The program does not provide treatment but requires the doctor to comply with conditions concerning work and treatment and progress through an individualized pathway in their involvement with the Board according to the impact of the specific disorder (Wilhelm and Reid, 2004). A previous study of doctors involved with this program between 1981 and 2001 found that being older than 60 was associated with a significantly reduced prevalence of presentations to the program, which could be real or an artifact of referral and retirement patterns

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of older doctors (Pethebridge, 2005). Subsequently, there has been an increased number of notifications and an increased contribution of cognitive loss to impairment in older doctors that requires further investigation.

We undertook this study to gain an understanding of the patterns of impairment in older doctors that could both assist medical regulatory authorities in their dealings with aging practitioners and facilitate the planning of primary prevention strategies. In conducting this study we aimed to describe patterns of notification and impairment of doctors aged over 60 who had been referred to the NSW Medical Board. We hypothesized that older impaired doctors would suffer a variant of the "three Ds" (depression, drink and dementia) with cognitive impairment dominating the picture. We also hypothesized that the demographics of older impaired doctors would be similar to that of younger doctors, i.e. male, working in a rural setting and over-represented amongst the specialties of psychiatry, anesthetics and emergency medicine.

Method

The NSW Medical Board's Health Committee reviews all notifications of potentially impaired registrants. Where there is an indication of impairment it then refers the registrant for examination by an independent Board-nominated specialist. If it is considered that the doctor is impaired, as defined by the Act, the Board then convenes an Impaired Registrants Panel, comprising two members who meet with the registrant and consider the reasons for notification, the report from the Board-nominated specialist, and, if available, any other specialist reports to determine if it is necessary for conditions (including suspension) to be imposed on the doctor's registration.

Consecutive case records were examined of such notifications of doctors aged over 60 years to the NSW Medical Board from January 2000 to January 2006. Demographics, including age, gender, marital status, specialty, locality of practice and referring person, were collected. These were compared with comparable data from the Australian medical workforce aged over 65 (AMWAC, 2005). Results of any cognitive examination, including scores on the Mini-mental State Examination (MMSE) and, if available, neuropsychological assessment, together with psychiatric diagnosis and outcome of assessment were recorded.

Medical morbidity was assessed using the Cumulative Illness Rating Scale (Geriatric) (CIRS-G) which provides a quantitative rating of chronic illness burden in geriatric patients with good inter-rater reliability and face validity (Miller *et al.*, 1992).

Standard qualitative analysis techniques (Rice and Ezzy, 2004) were used to interpret data relating to work patterns, insight into impairment and understanding of involvement with the Board. Data were subjected to methods of grounded theory and thematic analysis (Rice and Ezzy, 2004) to identify recurrent themes of work patterns and attitudes toward retirement.

Ethics approval was obtained from the NSW Medical Board and confidentiality of subjects was maintained by removal of all identifying data.

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Results

There were 70 notifications to the Health Committee in the period under examination, comprising 41 cases of impairment, which formed the focus of this study, 14 "vulnerable" doctors, 11 cases in which no psychiatric diagnosis or impairment was found, and four cases in which the doctor had notified the Board of a problem and no further action was required (a 67-year-old doctor with carcinoma who subsequently died; an 88-year-old retired doctor with meningioma; an 85-year-old retired doctor with multiple health problems; and a 64-year-old doctor with protracted delirium who had his name removed from register). "Vulnerable" doctors comprised doctors with a range of problems (e.g. attitudinal and personality problems, treated depression, adjustment disorder, inappropriate prescribing, alcohol-related driving charges) in which impairment or loss of judgment was suspected but there was no evidence of impairment impacting on their capacity to practice as defined by the Act.

Demographics

When compared with comparable data from the Australian medical workforce aged over 65 (Table 1), the data suggest a similar preponderance of male doctors amongst the impaired group and a trend for an over-representation of overseas-trained doctors amongst impaired doctors. General practitioners

Table 1 Demographics and specialty of impaired doctors

	IMPAIRED DOCTORS (N = 41)
Mean age (SD)	70.7 (8.3)
Age range	61–95
Male – no. (%)*	36 (88%)
Married (%)	66.7%
Overseas trained*	53%
Work > 35hrs/week	53%
Specialty	
GPs*	29 (71%)
Dermatologists	1
Psychiatrists	2
Surgeons	3
Geriatricians	1
Anaesthetists	1
Physicians	1
Pathologists	3
RMO	-

*Australian medical workforce data (AMWAC, 2005): 90% male; 10–30% overseas trained; 47% GPs
GP = general practitioner; RMO = resident medical officer

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(GPs) appeared to be over-represented with equal representation of other specialties.

Patterns of notification

The most frequent source of referral was from the State Pharmaceutical Services Branch (PSB) or local pharmacies (27%; N = 11) which identified transgressions in prescribing drugs of addiction such as narcotics or benzodiazepines. This was followed by treating doctors (17%, N = 7); hospital administrators (12%, N = 5); sections of the Medical Board (10%, N = 4) and self referral (10%, N = 4). Less frequently, doctors were referred by the police (7%, N = 3), by virtue of their psychiatric inpatient status (7%, N = 3), by colleagues (7%, N = 3), or by the local community aged-care team (2%, N = 1).

Boundary issues

Manifest problems with boundary issues were frequently observed amongst impaired doctors who had difficulty denying inappropriate patient requests and perceiving appropriate bounds to empathy. This was often exploited by substance-abusing patients who "stood over" these often frail doctors.

Some doctors had insight into their vulnerability. A mildly cognitively impaired female doctor, working in a solo inner-city practice, defended her excessive prescribing of benzodiazepines: "they target me because I have no big muscles". Another doctor with insight stated: "I have trouble dealing with demanding patients. I'm not good at saying no. I'm struggling with people who lean on me."

Others had no insight. When a cognitively impaired doctor, who was identified as overprescribing benzodiazepines, was asked to defend his prescribing patterns he was noted to be perplexed and stated: "that's what the patient asked for." An appointment diary/medical record recorded attendances of up to 20 patients per day each with benzodiazepine noted next to their name, the same patient often presenting on consecutive days. Another doctor with early dementia and psychosis was accompanied by two drug-dependent patients ("friends") to his assessment interview. He saw himself as the champion of patients whom he perceived as underdogs, victims of poor pain management, restricted analgesic supply and doctors who wouldn't do home visits:

> "I'm the only one. We're in terrible trouble here. People are in strife and in pain. I have my morals."

Nature of impairment

Cognitive impairment

Cognitive impairment or dementia was found in 53.7% (22/41), including 12% (5/41) having frank dementia. The mean MMSE score among those impaired doctors in whom an MMSE had been performed was 27.9 (SD 2.6, N = 14; range 21–30).

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Typical neuropsychological findings included:

- long-term memory well-preserved, as were consolidated verbal skills;
- auditory memory and learning abilities were significantly lower than expected given superior verbal intelligence;
- decreased ability to commit novel information to memory and retain it after short delay;
- slowing of information processing, visual scanning, motor and mental slowing;
- problems in planning, abstraction, cognitive flexibility and generativity;
- preserved ability to cope with routine medical problems/well-known patients by drawing on existing knowledge base;
- difficulty in dealing with complex or unusual problems,
- difficulty in retaining facts from recent patient consultations, recent reading;
- tendency to be rigid and concrete in thinking.

Substance abuse

Any form of substance abuse was found in 28.9%, alcohol abuse or dependence in 19.5% (8), opiate with or without benzodiazepine abuse in 17.1% (7). Of those with alcohol abuse, four developed the disorder late in life, while three of those with opiate use developed the disorder later in the context of intractable pain or a specific stressor such as marital conflict. Three of the doctors with alcohol-related disorders were identified due to charges related to driving under the influence of alcohol.

Psychiatric morbidity

Depression was found in 21.9% (9). One doctor had bipolar disorder. Other diagnoses included personality disorder (1); self-prescribed steroid abuse (1); central nervous system disorders: Parkinson's disease (1); multiple sclerosis (1); and psychotic reaction (2). There were two or more psychiatric or neurodegenerative disorders in 17.1% (7) of impaired doctors (including depression or psychosis and cognitive impairment (2); depression and substance disorder (3); cognitive impairment and substance disorder; and (1) cognitive impairment and multiple sclerosis (1)).

Medical morbidity

Mean CIRS scores 7.3 (SD = 3.2) were more akin to previously published means for elderly medical clinic patients (means 8.2–10.6) than for healthy controls (mean = 4.5) (Miller *et al.*, 1992).

Work practices

Of 31 impaired doctors, 19% (6), worked from home, including two with surgeries in their kitchens. Some 57% (16/28) had solo practices (by way of

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comparison, 25% of doctors with no impairment had solo practices) and 29% worked in a rural or small regional setting.

Two work patterns – "workhorse" and "dabbler" – were observed, as illustrated by the following quotes:

Workhorse: 71 year old: "I work 50–60 hours per week, I'm on call 24 hours per day, do house calls 7 days per week.
75 year old: "I was in the top 18% of the country in terms of the number of patients I see."
85 year old: "pursuing other interests is all terribly self-centered"

Dabbler: 79 year old: "It's only twenty patients per month in the kitchen, so it doesn't matter."
95 year old: "I see three patients per day from home . . . my patients are my friends."

For many doctors, a culture of avoided or postponed retirement due to sense of obligation and working "until you drop" predominated:

- 95 year old: "In defense, I never refused work even at the cost of personal and domestic commitments . . . There's no-one else in the town that will help these people [I'll stop working] when I peter out . . . when I drop dead."
- 80 year old: "I'll keep working to keep my mental capacity going; I enjoy it. It's a reason to get out of bed."
- 74 year old: "I worked all my life and had not learned to do anything else – great difficulty knowing what to do were I to stop working."
- 61 year old: ". . . felt relief as if a great weight had been lifted when showed me reports of testing. Resolved a conflict between a feeling that I had to keep going and struggle to do so . . . felt a responsibility for staff members in the practice."

Insight and resistance to intervention

There was a high degree of denial of the impact of the illness on the impaired doctors' medical career:

- "If I have a significant illness that is my problem not yours" (65-year-old surgeon, alcohol-dependent)
- "Apart from the fact that there is no need to do so, I won't attend a medical exam . . . I was unaware that this outfit was an annex of the NSW Police Force" (77 year old with alcohol abuse)

Complaint history

Some 48.6% (18/37) of doctors were subjects of patient complaint or poor performance within ten years of presentation. This manifested as a series of low-level patient complaints and included histories of inappropriate prescribing,

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performance issues such as poor maintenance of drug register and record keeping in general.

Outcome

At last file entry, 4.9% (2/41) of the doctors had died in our survey, 11 (26.8%) were working with conditions placed on them, and the rest had been suspended, had their names removed from the register or had chosen non-practicing registration.

Discussion

To our knowledge there has been no other comprehensive examination of the demographics and patterns of impairment in older doctors. While younger doctors are more prone to suffer "the three Ds"– drugs, drink and depression (Schattner *et al.*, 2004) – we found that older doctors suffer the *four* Ds – drugs, drink, depression and dementia. As predicted, cognitive impairment predominated as a cause of impairment, although surprisingly, narcotic use was still a factor in the impairment of older doctors.

The issue of cognitive impairment amongst doctors poses several problems for regulatory bodies: (i) difficulty of detection amongst highly intelligent individuals with preserved verbal skills, who understand the significance of some of the symptoms and signs they are manifesting; (ii) difficulty of referral if they have patients and colleagues who protect them, either in a benign fashion or in an exploitative fashion; and (iii) the difficulty of extrapolating neuropsychological data to the medical workplace (i.e. the uncertain ecological validity of neuropsychological data).

With regard to detection, cognitive screens are not sensitive enough to detect early or mild impairment in this group who can still score well in even mild to moderate dementia. For example, the ceiling effects of the Mini-mental State Examination are well-known (Ihl *et al.*, 1992). This reinforces the need for requirements of regulatory bodies to supplement cognitive assessments by geriatrician or psychogeriatricians with neuropsychological assessments. At the other extreme, that there were doctors practising with Mini-mental State scores as low as 21 or 24, and frank dementia confirms that impaired practitioners are being protected and not identified until late.

Although cognitive impairment predominated, the prevalence of substance abuse cannot be ignored. It has been previously observed that referral of doctors for alcohol misuse often occurs later in life reflecting the lack or reliability of early warning signs in identifying this problem and the degree of denial by registrants and those around them (Wilhelm and Reid, 2004). A surprising finding from our data was a prevalence of narcotic use almost equal to alcohol abuse and sometimes complicated by depression or cognitive dysfunction. This, of course, represents doctors who are identified as being impaired and contrasts with other studies based on more naturalistic sampling, which have showed lower psychoactive drug use amongst older doctors (Farley and Talbott, 1983; Domenighetti *et al.*, 1991).

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The impaired doctors reflected a broad range of specialties, unlike the pattern seen in younger impaired doctors where the specialties of anesthetics, emergency medicine and psychiatry are over-represented (Pethebridge, 2005). The apparent over-representation of GPs and overseas-trained doctors in our series needs further investigation. Older impaired doctors are often isolated, working in rather inappropriate solo practices and report their patients to be their friends. Older physicians per se tend to work more frequently in solo practices (Wakeford *et al.*, 1986). At times, this leads to a self-perpetuating cycle of withdrawal, lack of peer review and support and incompetence: "collegial relationships become less rewarding and indeed often threatening as physicians start to become concerned about their competence and feel the need to hide self-perceived deficiencies" (Sadavoy, 1994).

There may be a cohort or systemic effect to the culture of solo practice and postponed or avoided retirement. This cohort may be part of the "old guard" who are used to doctors practicing on their own rather than working as team. Later cohorts of doctors may find that increased emphasis on teamwork and continuing medical education force them to be more reflective.

The sense of duty toward patients and work partners was an important reason why doctors continued working despite impairment. The sense of conscience toward patients and colleagues has previously been cited as justification for avoiding working through illness and expecting colleagues to do the same, leading to a push for doctors to underpin priority of patient care with self knowledge and self care (Thompson *et al.*, 2001).

The practice of medicine imposes an intrinsic and deeply felt psychological identity, the potential loss of which can be particularly threatening for doctors as they age (Sadavoy, 1994). Most want to retain the title of doctor and the right to prescribe and refer to family and friends and guard this jealously (although this may not always be in the interests of the family and friends). In many states of Australia the options of Limited Prescribing and Referral Registration (a subject of some debate) and Non-Practising Registration are available, and most Australian regulatory bodies will offer advice and support to older doctors in their career decision-making, preferring to channel them through more informal pathways for dealing with these issues.

The need for early identification and intervention is important. Patient complaints and conduct issues are possibly early warning signs of future impairment, especially if this is new, i.e. the doctor has never previously come to the attention of regulatory authorities. Similarly, alcohol-related driving charges, particularly if they are atypical, may be a pointer to possible impairment. The group of "vulnerable" doctors illustrates the high threshold at which doctors – some of whom are displaying intermittent errors of judgment – become impaired according to regulatory definitions.

Currently, incompetent or "dyscompetent" physicians are identified in most countries either through legal systems (when things have already started going wrong) or through peer review, with some provinces in Canada requiring mandatory peer practice review for physicians over a certain age. Although peer review has considerable face validity as a method of identifying incompetent physicians, it has its weaknesses and there is no other proactive method for identifying incompetence, nor is there consensus on an operational definition

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of medical incompetence (Williams, 2006). Recommendations regarding tiered screening (i.e. screening of "at risk" populations such as older male physicians in solo practice to identify those in need of more comprehensive assessment) (Williams, 2006) need to be investigated and consensus-based guidelines developed.

Our findings must be interpreted in the light of several important limitations. First, this was a qualitative descriptive study of a small sample intended to stimulate further study and debate. There was no control group, although some comparisons were possible using Australian Medical Workforce data. Secondly, this study was limited by being based on a case file review and by the information gathered by the Medical Board and thus data are based solely on what has been recorded. This may have led to an underestimation of some of the associations. Finally, our study is based on those impaired doctors who have come to the attention of the Board and thus represent only a subset of the total population of impaired doctors.

We need to encourage doctors to adapt to age-related changes and validate their right to timely and appropriate retirement when appropriate. Also, we need to encourage doctors to expand their interests outside medicine, starting in their 40s and 50s, with a view to planning for life after medicine. The profession as a whole and the Medical Boards need to facilitate career paths and retirement planning for older doctors.

Conflict of interest

None.

Description of authors' roles

Dr. Peisah was responsible for formulating the research question, designing the study, carrying out the file review, analyzing the data and writing the paper. Professor Wilhelm was responsible for formulating the research question, designing the study and writing the paper.

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