Aging healthcare professionals

There is no lack of published material on the psychological morbidity and job satisfaction of junior doctors but when doctors, their nursing colleagues, and other health professionals grow older they are apparently not such a popular group to study. Research in various countries has shown high rates of psychological morbidity among doctors in several specialties in mid-career, but the publications contain few specific references to doctors or other health professionals who are nearing retirement age. Studies of other workers, particularly by occupational health groups in Finland, have shown definite decrements in performance with age and difficulties in adaptation to change. The performance of doctors and nurses of all ages is of great public and political interest and the pace of change in most countries’ health services has never been greater.

In Britain, with the passing of the Medical (Professional Performance) Act 1995, the United Kingdom General Medical Council is preparing, for the first time, to assess medical practitioners whose standard of performance has been called into question and to apply sanctions or order retraining for those whose performance is regarded as substandard. In Britain and many other countries continuing medical education or continuing professional development schemes for nurses and other health workers operate to keep professionals abreast of new knowledge and help them to maintain their skills. In some countries this has extended to professional re-accreditation—a formidable challenge to the older health professional. How likely is it that the effect of age on health professionals will greatly impair performance? Could their work pattern be sensibly modified to offset this? Do occupational health services have a part to play in advising health professionals and their managers?

In 1993 in Great Britain the population of working age (all those men aged 16–64 years and women aged 16–59 years) was 34.6 million and this figure has risen over the past 20 years. The actual labour force numbers 27.1 million and in the past 20 years has increased by 3.2 million, most of whom are women. In fact there has been a fall in the number of people aged 55 and above at work, and a striking move away from hazardous industries into the service sector. The trend in the health professions is no longer to carry on working to an advanced age, and although there is variation between countries, doctors and others are retiring earlier with the consequence that a notable increase in aging healthcare professionals is not expected.

The absolute number of healthcare professionals of all ages in the United Kingdom National Health Service (NHS) in 1994 was:
- Medical and dental 61 610
- Nurses 444 610
- Professional and technical 115 190
- Total 621 410.

This represents nearly 2% of the total labour force and a higher proportion of the professional and technical labour force. The number entering the healthcare professions in most countries is currently rising.

Despite the well known increased mortality in doctors from liver cancer (proportional mortality ratio (PMR) 190), cirrhosis (PMR 203), other alcohol related deaths (PMR 133), and suicide (PMR 162), and of dentists from suicide (PMR 194) and prostatic cancer (PMR 159), and nurses from suicide (PMR 127) health professionals have a low all cause mortality (81–89) and in the Office of Populations, Censuses and Surveys’ longitudinal study, nurses have a significantly low SMR of 70–90 and doctors of 67. There are no particularly outstanding causes of death in other categories of health professionals and in all health professions no trend greater than the average towards increased mortality with age. Clearly the problem does not lie with mortality but with morbidity and, from the viewpoint of the occupational health practitioner, with performance.

At the inception of the United Kingdom NHS in 1948, when the national retirement age was for men 65 and for women 60, certain healthcare workers were considered to be in a special class due to the supposed extra strain which their jobs put on them and they were allowed to retire at the age of 55. The categories were female nurses, physiotherapists, midwives, district nurses, and occupational health nurses. Mental health officers (nurses or doctors) also came into this category, whatever their sex. This special class status was dropped for new entrants in 1995 and now all healthcare professionals have a notional retirement age of 60. There has been a recent increase in voluntary early retirement which is allowed over the age of 50. The European Union is working towards a common retirement age for men and women; in many other countries the influence of the state on retirement age is lessening; more flexibility is being introduced, and there is more self employment and more negotiation with employing bodies.

Medicine is not a notably physical occupation but nursing still is—despite the advent of complex patient handling systems. With age comes muscle wasting, a decrease in bone density, especially in women, declining respiratory capacity, and perhaps more sensitive skin. Special senses are important in medicine and age brings with it a decline in taste, smell, sight, and hearing. The incidence of tinnitus increases. As vision declines there is presbyopia, an accentuation of previously notable refractive abnormalities, reduced colour discrimination, reduced appreciation of contrast, and increased time to recognise visual information. Visual testing and optical correction is clearly important to surgeons, anaesthetists, theatre technicians, etc and healthcare professionals with poor hearing should recognise the fact and arrange investigations, treatment, or the use of hearing aids.

There may be a decline in intellectual performance with age—occasionally a considerable decline, but many people continue unimpaired.

Perhaps the greatest changes that occur in the later life of health professionals, apart from the obvious increasing likelihood of physical illness, are psychological problems. Many countries have produced studies of doctors who have become depressed, demoralised, or burnt out by a lifetime’s hard work with a demanding public and perhaps a neglected home life. After all, later life is not seen as a time for growth and achievement, yet older healthcare workers are being expected to work harder, work to higher standards, and cope with exceptional changes in the workplace and work ethos.

Abilities may change: aging decreases the ability to recover after several night shifts and increasing fatigue is often found or reported in older doctors who find that night calls get more and more tiresome and have a disproportionate effect on the next day’s work. Older doctors who descend into reminiscence to protect their self worth and who operate less analytically, but more by the accumulation of experience, achievement, and “wisdom” may find
this difficult now that evidence-based medicine is being promulgated as a future mode of medical practice. Objectivity gets replaced by “bewitchment by expectation, myth and ill-informed stereotype”.

On the other hand, like politicians, soldiers, and many animals the leaders of the medical and nursing professions are generally old; they have more prestige and are more influential.

How can older health professionals be helped to identify their limitations in advance, respond to the changing climate, and perhaps change the nature of their job to suit their new circumstances? Doctors do not look after their own health particularly well; nurses and other professionals are not so bad. It should be compulsory for all doctors to be registered with a general practitioner or in certain circumstances have access to an occupational health service that might be in a position to arrange vision testing, audiometry, or psychometric evaluation. They may be able to arrange preretirement courses and even strength, fatigue, dexterity, and reaction time testing where appropriate.

No doctor or nurse once they have reached a senior level should be expected to continue to work at the same rate or to cover the same range of problems until retirement. Sabbaticals and secondments should be encouraged and the development of evolving job plans is an important step forward. Healthcare professionals throughout the world are losing their autonomy and becoming more answerable to managers, whether in socialised systems of healthcare or in health management schemes. They should have full input into their job plans and some kind of annual review process. It is sensible to run down the amount of work done by health professionals in the 10 years before retirement and to change the nature of the job progressively allowing for more teaching, more mentoring, less nightwork, less operating, less travelling, and more team integration. Occupational health teams should have the skills to work with professionals and healthcare facility managers to promote sensible changes in job design for older workers. If the accumulated skills and experience of older professionals are recognised, used, and valued, their feelings of cynicism and exhaustion will diminish and their contribution will improve until the day they can depart with enough energy to enjoy their retirement.

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Medical editors trial amnesty

As described in an editorial in the British Medical Journal, medical editors of nearly 100 international medical journals are taking action to try to ensure that the results of unpublished randomised controlled trials become available to be included in systematic reviews. This could have important benefits for patient care.

Any reader who would like to take up this opportunity to register the results of a trial that did not get published can do so on a special unreported trial registration form. Copies are available from the Occupational and Environmental Medicine editorial office.

I do not expect that many Occupational and Environmental Medicine readers will need to take up this offer, given the nature of our field, but perhaps I will be proved wrong.

ANNE COCKROFT
Editor