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# Ageing, cognitive disorders and professional practice

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## Abstract

**Background:** the workforce is ageing. The contribution of older workers is considerable. Their occupational health profiles differ from those of younger workers.

**Objective:** we wished to establish whether consideration has been given by regulatory and professional bodies of the impact of ageing-related conditions such as dementia on professional practice.

**Methods:** We e-mailed a questionnaire to 22 regulatory and professional bodies in the UK and the Republic of Ireland. We asked whether there are supports for their practitioners should they develop age-related diseases, (particularly cognitive disorders), whether the body considered that the practitioner was responsible for their own health, and whether the body has resources to arrange for medical review for their professionals if concerns arose regarding competence. Where bodies did not respond, information relating to the questions was extracted from their on-line resources.

**Results:** thirteen bodies responded. None of these had specific supports to assist older workers. Some knew of other supports (occupational health, employee assistance supports, benevolent funds or counselling services). All of the bodies who responded either have or are developing structures to deal with concerns regarding their practitioners.

**Conclusion:** The absence of specific policies for age-related diseases, (particularly dementia), among professional and regulatory bodies is a challenge for an ageing workforce in the liberal professions. Closer working between geriatric medicine, old age psychiatry, occupational health and professional bodies is recommended to develop age-attuned policies and systems which protect the public while supporting the professionals in both work and timely transition from work.

**Keywords:** *dementia, Alzheimer's disease, occupational health, professional practice, professional regulation, older people*

## Introduction

Life expectancy is increasing. Currently, a retiree at the age of 65 can reasonably expect to live for a further 17.8 (if male) or 20.4 (if female) years [1]. At the same time, the amount of

savings required to both maintain one's standard of living and to cover healthcare and other costs have risen exorbitantly [2, 3]. The potential demands that this puts on retirement and pension funds are well recognised [4]. Now a number of countries, including the UK, are rising the age at which state pensions are

granted. Furthermore, increasing numbers are now employed in service roles that require cognitive demands rather than more traditional physically demanding roles (e.g. manufacturing), and this may also influence their willingness to delay retirement [5].

As a result, there has been an increasing trend (for both personal well-being and financial reasons) to remain in work for longer [6].

Currently, almost 1 in 10 of the population over the age of 65 years continue in employment [7]; 9.2% of the population over the age of 65 were in employment in the UK in the last quarter of 2012 compared with 8.5% of this age group for the same period of 2011 and 5% in 1992 [7, 8]. This represents a major shift from the situation up to the 1980s, where an increase in economic wealth and generous pension plans allowed workers to consider early retirement [9]. Now, not only is there a recognised need to attract and retain older workers [10], but also an increasing recognition of the extra benefits that they bring to the workplace in terms of experience, wisdom and reliability. This changing demographic, i.e. the ageing workforce presents new occupational health (OH) challenges.

Research examining the occupational well-being of older workers has tended to concentrate on the physical aspects of increasing age. For example, it has been estimated that physical work capacity declines by ~20% between the ages of 40 and 60 years [11]. A relatively neglected aspect is the intersection between a common age-related syndrome, dementia and work capacity. Although the prevalence of dementia is relatively low at 'younger' old age, it rises steeply after the age of 75 [12]. Older workers are regarded as more loyal than younger workers [13] and bring an invaluable 'wealth of experience' to the workplace [14]. Therefore, with respect to fitness for work, the potential impact of age-related conditions (e.g. reduced dexterity, cognitive decline etc.) should be considered in parallel with the positive aspects of ageing (e.g. wisdom, strategic thinking).

The impact of cognitive disorders is likely to be of particular significance to the liberal professions, such as architects, doctors, engineers, lawyers, pharmacists and veterinary surgeons [15], whose work requires 'a high level of legal and technical' knowledge, and who are 'subject to the code of conduct applicable to that profession drawn up by the appropriate professional body with a focus on the interests of those who seek services from the professional concerned' [16]. Not only does their daily practice require sophisticated decision-making which may affect the lives of many but they also have considerable discretion over when they retire and are likely to work into later life; in addition they are not usually supported by formal OH services. Thus, the regulatory and professional bodies of the liberal professions have responsibilities when concerns arise regarding work quality.

As a result of a number of cases at the local geriatric medicine out-patient service involving professionals who had continued to work in later life and had developed dementia while still working, we were concerned that their professional bodies had not yet developed policies and

procedures for their members who might be affected in this manner.

We, therefore, undertook a survey of professional bodies representing the major professions in the UK and Ireland. The aim of this study was to establish whether professional and regulatory bodies had age-attuned their policies on health and professional practice.

## Methods

We sent a questionnaire to 22 regulatory and professional bodies; these bodies were selected as they represented the major liberal professions which had representation both in the UK and Ireland. Where possible the questionnaire was sent to e-mail addresses for the professional competence committee; where such e-mail addresses were not available the questionnaire was e-mailed to addresses provided for general enquiries. In the accompanying letter, we advised that we sought to establish whether consideration had been given to the possibility of professionals being referred who had medical problems associated with ageing, including cognitive difficulties (i.e. Alzheimer's disease), and whether their supports and regulations would be sufficient to support their older members with cognitive difficulties remain in work.

The questions we posed were as follows:

- (1) Do the relevant professions have a support service for practitioners who are unwell, which would enable them to continue working?
- (2) If so, what is the nature of the support available?
- (3) Who administers and/or oversees this service?
- (4) Are professionals expected to take responsibility for their own health in relation to their own fitness for work, which is considered separately from judgements regarding their competence?
- (5) If a professional was deemed incompetent, are they required to undergo a formal medical review process? Who is responsible for co-ordinating such an assessment and who would carry it out?

The questionnaire was sent by e-mail in January 2012. If no response was received after one reminder e-mail, where possible, information was extracted from the professional or regulatory body's on-line resources.

## Results

We contacted bodies representing accountants, allied health professionals, architects, barristers, dentists, doctors, engineers, pharmacists, physiotherapists, solicitors and veterinary surgeons. Of the 22 regulatory and professional bodies we contacted, 13 responded; of the healthcare-related professional bodies contacted (dentists, doctors, allied health professions, physiotherapists) ( $n = 8$ ) all but one body responded. We were able to acquire further information from the websites of the nine that did not respond (Table 1).

Table I. Responses and on-line data for regulatory bodies

Profession	Body	Correspondence (C), website (W)	Are professionals expected to take responsibility for their own health in relation to their own fitness for work, which is considered separately from judgements regarding their competence?	If a professional was deemed incompetent, are they required to undergo a formal medical review process?	Who is responsible for co-ordinating such as assessment and who would carry it out?	Who would carry out the medical assessment?
Accountants	Association of Chartered Certified Accountants (UK)	W <a href="http://www.acca.org.uk/">http://www.acca.org.uk/</a>	Not stated	Not explicitly stated for fitness to practice concerns, but mentioned as part of disciplinary process (inability to attend for disciplinary process)		
	Chartered Accountants Regulatory Board (Ireland)	W <a href="http://www.carb.ie">www.carb.ie</a>	Not stated	Not stated		
Architects	Architects Registration Board (UK)	W <a href="http://www.arb.org.uk">http://www.arb.org.uk</a>	Yes	Not stated		
	Royal Institute of Architects of Ireland	C, W <a href="http://www.riai.ie">www.riai.ie</a>	Not stated	Not stated		
Barristers	Bar Standards Board UK	W <a href="http://www.barstandardsboard.org.uk">www.barstandardsboard.org.uk</a>	Not stated	Yes	The medical panel	Medical advisors are appointed by the medical panel
	Bar Council Ireland	W <a href="http://www.lawlibrary.ie">www.lawlibrary.ie</a>	Not stated	Yes, prior to resumption of work as a barrister	Not stated	Not stated
Dentists	General Dental Council (UK)	C, W <a href="http://www.gdc-uk.org">www.gdc-uk.org</a>	Yes	Not stated		
	Dental Council of Ireland	C, W <a href="http://www.dentalcouncil.ie">www.dentalcouncil.ie</a>	Yes	Yes		
Doctors	General Medical Council (UK)	C, W <a href="http://www.gmc-uk.org">www.gmc-uk.org</a>	Yes	Yes	The GMC makes the arrangements	Two doctors selected by the GMC (frequently psychiatrists)
	Irish Medical Council	W <a href="http://www.medicalcouncil.ie">www.medicalcouncil.ie</a>	Yes	Not stated		
Engineers	Engineering Council (UK)	C	Yes	No		
	Engineers Ireland	C	Not stated	No		

Other health profession regulators	Health Professions Council (UK) <sup>a</sup>	C, W <a href="http://www.hpc-uk.org">www.hpc-uk.org</a>	Yes	Yes	The Health Committee	Professionals may submit their own medical report, or the HPC may commission expert medical evidence. (Fitness to practice process)
	Coru (Health and Social Care Professionals Council) <sup>b</sup> (Ireland)	C, W <a href="http://www.coru.ie">www.coru.ie</a>	Yes	Yes		
Pharmacists	General Pharmaceutical Council (UK)	W <a href="http://www.pharmacyregulation.org">www.pharmacyregulation.org</a>	Yes	Yes	The General Pharmaceutical Council	Not stated
	The Pharmaceutical Society of Ireland	W <a href="http://www.thepsi.ie">www.thepsi.ie</a>	Not Stated	Not stated		
Physiotherapists	Chartered society of Physiotherapists (UK)	C	Yes	Not applicable. The profession is regulated via the Health Professions' Council		
	Irish Society of Chartered Physiotherapists	C	Yes	Yes	Co-ordinated by the Professional Procedures/ Ethics committee of the society.	Committee nominates a medically qualified referee and the member is asked to attend for examination.
Solicitors	Solicitors Regulation Authority (UK)	W <a href="http://www.sra.org.uk">www.sra.org.uk</a>	Not stated	Not stated		
	Law Society of Ireland	C	Yes	Yes	One of the Society's Regulatory Committees.	Doctor may be appointed by the society, depending on the circumstances.
Veterinary surgeons	Royal College of Veterinary Surgeons (RCVS)	C	Yes	Yes	The Preliminary Investigating Committee of the RCVS	A medical examiner nominated by the Preliminary Investigating Committee
	Veterinary Council of Ireland	C	Yes	Yes	The fitness to practice committee	A medical practitioner nominated by the committee

All websites last accessed 25 May 2013.

<sup>a</sup>Currently regulate 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers and speech and language therapists.

<sup>b</sup>Currently the register of social workers is the only one open. Further professionals to be included in Coru include clinical biochemists, dieticians, medical scientists, occupational therapists, orthoptists, podiatrists, physiotherapists, psychologists, radiographers, social care workers, social workers and speech and language therapists.

Although some of the bodies knew of benevolent funds or counselling services that were available for their professionals, none of those we contacted in this study had supports intended to support older workers remain in work. Some bodies referred to supports that may be available to practitioners from their employers (i.e. OH services, employment assistance supports).

Fourteen of the twenty-two bodies stated that practitioners are expected to take responsibility for their own health.

All of the regulatory and professional bodies who responded have (or are in the process of developing) the capacity to deal with complaints or concerns regarding practitioners. Where a health concern has been identified, only 11 of the 22 bodies have the facility to refer practitioners for medical examination.

## Discussion

None of the bodies included in our study had developed supports that were specifically designed to facilitate older workers with chronic progressive medical problems, such as dementia, remaining in work.

Some professional and regulatory bodies mentioned their benevolent funds (e.g. Engineering Council, Engineers Ireland, Irish Society of Chartered Physiotherapists). Both the General Medical Council and the General Dental Council were aware of benevolent funds that are operated by external agencies. It is not clear what extent of assistance can be provided by these funds. The use of OH services and employee assistance programmes were recommended by some of the bodies we contacted, to be provided by the practitioner's employer. Professionals who are self-employed do not have access to these supports.

The ageing of the workforce poses new challenges to OH as traditionally it has focused on the health, safety and welfare of workers aged between 18 and 65. For those working into later life, additional considerations are necessary [17]. These include the impact of morbidity associated with ageing on workability and the need to change work practices to accommodate the different physical and cognitive capacities of older workers [18–21]. The Black Report on OH in the UK emphasised the importance of OH and early intervention for those who develop a health condition so that supports are available for those with the potential to work [22]; the report also raised the issue of OH provision for those outside the traditional remit of OH, such as the self-employed and the unemployed.

Imaginative proposals have emerged from Finland for age-attuning of the work place and OH services [18, 23] including flexible/partial retirement, changes in the work environment to promote the workability of older adults (e.g. appropriate ergonomic practices) and initiatives to optimise the health and capacity of the individual worker (e.g. supervisor training, employee training on new technologies) [23]. As a consequence, the employment rates of older workers have increased [24]. Extending these principles to

environments not covered by OH services is a challenge, but one that might usefully be developed within the context of professional and regulatory bodies for professionals. Failure to provide timely diagnosis and support for those in the professions who acquire Alzheimer's disease or other dementia may have harmful consequences for their clients or patients. Early recognition can be difficult: the high levels of education associated with these professions are generally considered to be protective against the onset of dementia [25], but also may in part serve to mask the onset of the illness; there can be difficulties distinguishing between the changes associated with normal ageing, mild cognitive impairment and dementia [26]. Fourteen of the twenty-two bodies in our study specified that their professionals were required to take responsibility for their own health, and limit work if there is a problem with performance or judgement. By way of example, the GMC recommends that doctors consult a colleague if they believe that their 'judgement or performance could be affected by a condition or its treatment'. Anosognosia (i.e. unawareness or denial to the deficits) of memory and cognition are common in dementia and explain the frequent lack of insight into the problems encountered [27]. All those affected need to cease practice in a timely manner. Currently, however, there is an assumption that the practitioner has an awareness of the problems faced, and insight is rarely considered.

All of the bodies who responded have (or are developing) structures to manage complaints or concerns regarding their professionals. These concerns are managed either through ethics panels or fitness to practice committees (which may be known by other names, such as the Engineering Council's Professional Conduct panel or the Health Professions Council Investigating Committee); however, the primary role of the regulatory bodies is to protect the public.

Where a health concern has been identified, only 11 of the 22 bodies have the facility to refer practitioners for medical examination. Such medical involvement could act to support the practitioner remaining in work (e.g. by informing whether limitations should be put on their practice, whether medical treatment is necessary, or whether unsupervised work should be restricted). The committee will generally review the case after a defined period, with the expectation that the practitioner will have recovered from the identified health problem. For many regulators, this process whereby professionals with medical problems can be assisted to remain in work developed to support practitioners with addiction problems. Thus, difficulties may emerge in chronic progressive medical conditions such as dementia, where support and supervision is likely to be required for the remainder of the practitioner's working life, although there will be a natural limit. Self-referral is rarely entertained; this type of support is generally only activated when a concern about a professional's practice has been raised.

The main limitations of this study is that we only contacted a selected group of professional and regulatory bodies, and only 13 of 22 of these bodies responded to the questionnaire. Most of the healthcare-related professions' bodies

responded. This may be due to the professionals engaged with these groups being more aware of the impact of ageing and dementia on workability, and therefore being more willing to respond to the enquiry, but we can only speculate on this. We believe overall, however, that this study demonstrates that currently there is only limited support available for practitioners who develop an illness such as dementia remaining in work, and that it is expected that professionals take responsibility for their own health concerns.

A fine balance is required in developing professional and OH approaches to cognitive disorders in an ageing workforce. On the one hand, it is important not to be alarmist about an illness that is likely to affect a minority of older workers, or to stigmatise older workers who in general have much to offer personally and collectively to the workforce yet already suffer from ageism. Within the liberal professions, even though there is little hard data available, it is clear that the potential impact of dementia on professional competence has not received the same attention as that of conditions such as alcohol or substance abuse. However, we need to protect individuals and their clients and develop mechanisms to detect when professionals are no longer capable of safe and effective work.

Individual practitioners need to be aware of the potential impact of health on work and that this can become more marked as one ages. Ideally, each profession should put appropriate structures in place to enable support to be provided proactively. One example is The National Clinical Assessment Service (NCAS) [28] in the UK. It provides advice for practitioners (doctors, dentists and pharmacists) and for their employers where there is a concern regarding the practitioner's performance at work. The advice is tailored to the individual practitioner and their problem. NCAS does not function as a regulator; its ultimate duty is to ensure public protection and patient safety. Rather it acts as an advisory service; the aim being to 'restore practitioners to safe and valued practice'. This type of model, i.e. an independent one that allows professionals to self-refer in a confidential manner, may encourage practitioners to source appropriate advice regarding their work practice prior to a significant deterioration in their work practice, allow for sequential assessment, support and monitoring, and for eventual withdrawal from practice in a dignified manner and minimise or eliminate harm to the public.

## Conclusion

To date, there has been minimal attention given to the potential impact of medical conditions, such as dementia, on liberal professionals' ability to continue working in a safe and effective manner. A joint initiative with the disciplines of OH, geriatric medicine and old age psychiatry could develop and adapt policies, procedures and guidelines to assist professional and regulatory bodies, and provide due protection for the public, for a differing profile of health issues among their older practitioner members. Dementia provides an ideal

focus for the development of such processes, and existing procedures for mental health issues may provide a useful starting point.

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## Key points

- The workforce is ageing.
  - Older workers are valuable members of the workforce.
  - Many older workers in the liberal professions do not have access to OH services.
  - Health practitioners should be aware that there may be only limited support available from representative bodies.
  - Age-attuned structures should be developed that provide support to practitioners while protecting the safety of the public.
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## Conflict of interest

None declared.

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## Exploring the relationship between national economic indicators and relative fitness and frailty in middle-aged and older Europeans

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### Abstract

**Background:** on an individual level, lower-income has been associated with disability, morbidity and death. On a population level, the relationship of economic indicators with health is unclear.