

A Personal Perspective from the UK: ageing and psychiatrists

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Abstract

Objective: Psychiatrists appointed to National Health Service (NHS) consultant posts in the United Kingdom before a specific date in 1995 qualified for early retirement and this has implications for workforce planning. The author reflects on the implications this has for ageing psychiatrists and for relationships between psychiatrists and patients and families using mental health services, from the perspective of a psychiatrist who took advantage of the opportunity to retire early from a consultant post in the NHS and to develop a new career.

Conclusions: Older psychiatrists continuing to practice after retirement from consultant roles may bring disadvantages and advantages. They may be a valuable resource for future mental health services, and they may be in a position to try out new ways of working which might be relevant to their younger colleagues in the uncertain future faced by mental health services at a time of austerity.

Key words: new ways of working; retirement; support networks.

Introduction

Retirement was a 20th century invention and constituted a major life event, involving cessation of active work at an agreed age and marking the transition into later life. The basic state pension was introduced in the United Kingdom (UK) in 1948 ¹: boys born in 1901 were expected to live to approximately age 45 and girls to age 49, but by 1999 the life expectancy of newly born children was 75 years for boys and 80 years for girls ², and it has continued to increase since then. In 1948 65-year olds were seen as 'old', and there was a belief that over 65s were less able to engage in gainful employment (particularly manual work demanding physical fitness). In the 21st century, people are living much longer in the stage of life that would previously have been described as 'post-retirement', and the emphasis for many jobs is on thinking and knowledge rather than physical strength. An added complication in the UK is that psychiatrists, who became members of the NHS Pension Scheme before 6 March 1995, qualified for what is called Mental Health Officer (MHO) status ³. This gave them the opportunity to retire from the NHS from the age of 55 years with a full pension, and early retirement of experienced psychiatrists has been a matter of concern in terms of workforce retention and planning in psychiatry.

Working life does not necessarily end with retirement, however: retired/ older NHS psychiatrists may move on to new challenges or take the opportunity to develop a special interest or a new interest within the field of mental health or elsewhere. The term 'unretirement' has been used to describe people who retire from one job but then go back to work, often part-time and perhaps in a somewhat different role ⁴, and, alongside this phenomenon, increasing numbers of people are not retiring and continue to work beyond what used to

be recognised as the traditional retirement age. There are also people who might be described as 'serial retirees', who retire from one job and move on to another⁵: I know some psychiatrists who could be described in this way. A report from the Office for National Statistics in 2012 found that the number of people working beyond state retirement age in the UK nearly doubled between 1993 and 2011⁶, and is predicted to increase further following the abolition of a compulsory retirement age. In Australia the pension age is also rising⁷ and one third of respondents to a survey carried out by the Royal Australian and New Zealand College of Psychiatrists said that they expected to retire in the next five years⁸. All these trends are likely to increase the numbers of ageing psychiatrists continuing to practice in both Australia and the UK in a variety of roles. What does this mean for us as ageing psychiatrists, and what does it mean for our patients and the patients' families?

Older psychiatrists in practice: relationships with patients and families

Draper and colleagues⁹ surveyed Fellows of the Royal Australian and New Zealand College of Psychiatrists on their attitudes to personal ageing. They were interested in perceived benefits and drawbacks of age on psychiatric practice, and concluded that attitudes towards personal ageing have little impact on psychiatric practice, but that this is a complex area. Old age psychiatrists self-select to specialize in working with older adults and are faced daily with people and families dealing with the impact of ageing. Older old age psychiatrists might be more likely to understand, and empathise with, patients facing the challenges of advancing age, or, alternatively, they might cope by distancing themselves from the changes brought by age and personal ageing amongst their patients and patients' families.

Nevertheless we might speculate that older patients may appreciate older psychiatrists working with them, regard them as more likely to understand the challenges of personal ageing, and perhaps that later life families may do likewise. However, increasing wisdom and experience is not inevitable with increasing age, and some patients may suspect older psychiatrists are either disconnected from their patients as they contemplate retirement on the horizon, or more likely to be of the view that they know best and should make the decisions. It has been pointed out that people may simultaneously hold conflicting views about ageing: for example, that age brings wisdom, and that age brings diminished cognitive function¹⁰. Thus, patients and families might discount the wisdom of experience of older psychiatrists, and take the view that younger psychiatrists are more likely to be familiar with the most recent advances in treatment.

The mental illnesses of later life may affect three or four generations of a family and the perceived generation of the old age psychiatrist may influence how those different generations perceive them and relate to them: this is another way that age may influence psychiatrist-patient-family inter-relationships across the whole of mental health.

Older psychiatrists in practice: support networks

There may be hazards in working late in life. The General Medical Council document 'The state of medical education and practice in the UK' examined variations in the standards of medical practice, and showed that psychiatry accounts for more complaints than would be expected relative to the numbers of practitioners on the Specialist Register, ie psychiatrists are over-represented amongst those doctors about whom the GMC receives complaints¹¹. Furthermore, doctors aged over 50 are more likely to face a complaint. The National Clinical Assessment Service (a service which works with concerns about the practice of doctors and others), in their 2006 document entitled Analysis of the First four years Referral Data, also reported an over-representation of psychiatrists in terms of complaints – approximately four times the rate of complaints in general medicine - and noted that, for consultants, risk of referral increased with age¹². Their later publication, NCAS casework The first eight years, also identified risks for older practitioners¹³. There are many factors that might be relevant to these observations, including the expectations that other professionals, patients and patients' families might hold in relation to older practitioners and the expectations that psychiatrists trained in a different service context hold about their relationships with patients, families and teams. One possible factor is the lack of support networks available to older practitioners, particularly those who working outside a standard NHS consultant job. In this position it may be more difficult to connect with a peer group of psychiatrists, to have the opportunity to debate dilemmas and challenges in everyday clinical work with a multi-disciplinary peer group, and to complete the processes necessary to revalidate and continue to practise under the procedures required by the General Medical Council¹⁴. Mandatory reporting of impaired doctors is compulsory in Australasia¹⁵, but does it protect the community and support doctors in need, or increase the risks by leading to doctors hiding their problems and eschew support?

A personal perspective

So why is this a personal perspective? I write as an old age psychiatrist who had MHO status and took early retirement from a consultant job in the NHS. Subsequently I set up a Limited Company, which undertakes a portfolio of work across my areas of interest, including clinical work, research, teaching, independent therapy and more. I had not planned to retire early from the NHS and took myself by surprise, but have enjoyed the challenge of developing new interests and learning how to run a small business. I saw 'retirement' as a lifestyle redesign. It was not about stopping doing things but about doing different things, and I was uncomfortable when I heard others say (for example) that I 'used to be' a psychiatrist (I quote my mother here, but I acknowledge she was of a generation with completely different experiences and expectations). Jokes about old age pensioners no longer seem funny: it's personal now.

In the UK there have been changes in the role of the psychiatrist¹⁶, under the banner 'new ways of working'¹⁷ and new workforce roles have been developed¹⁸, but concern has been expressed about de-professionalization in

some areas where new roles have been introduced¹⁹. (Newton's third law says that for every action there is an equal and opposite reaction: we would do well to remember this.) In Australia there have been similar discussions about the role of the psychiatrist²⁰ and initiatives involving new workforce roles²¹. It is puzzling why we still fail to share and learn from our experiences.

In the 1990s Draper, Winfield and Luscombe surveyed Fellows of the Royal Australian and New Zealand College of Psychiatrists aged 55 and over, and found that most retired by gradually reducing their hours and developing new interests²². More recently Eagles, Addie and Brown found that, when Scottish consultants were asked what changes in their job might lead them to retire later, the two most common responses were a reduction in managerial/administrative work, and the opportunity to develop a special interest²³. My work pattern now allows me to develop a range of special interests, but running the business involves learning how to keep accounts and organize the administrative side of work. The difference is that I'm in control of my work pattern – if I'm made an offer that sounds interesting, I'll probably do it. I'm trying to keep a lot of balls in the air as I write this paper. Finding a way to complete the processes involved in revalidation (and therefore to continue to practise) was stressful and confusing. I was given different advice by different people, but eventually took on a part-time locum job for a Trust, which has supported me through the process, and for this I am very grateful.

Conclusion: advantages (and disadvantages) of ageing psychiatrists in practice

Older psychiatrists continuing to practice may bring disadvantages: they may have a different approach to the doctor-patient relationship or have become wedded to treatments, which worked in other contexts, and are now no longer relevant to modern practice. They may have physical or mental health problems themselves which impact on their work. They may be regarded as denying the realities of increasing age and as a consequence disregarded or professionally under-mined. They may be seen as relating to older patients and later life families at the expense of younger patients and families at an earlier stage of their family life cycle. From my position, I conclude that these potential disadvantages are outweighed by the particular advantages that older psychiatrists may bring to their work, in terms of understanding and relating to challenges faced by patients and families, experience gathered over many years of ways to deal with those challenges, and a long view of how services develop and change. By continuing to be involved with families they demonstrate that life is multi-generational and that older people continue to be active and to contribute to society (although one doesn't have to do paid work to contribute to society – that's another myth²⁴). They are also an important potential resource for the UK, Australia, and countries across the world. Perhaps they are in a position to develop and try out new ways of working which might be relevant to their younger colleagues in the uncertain future faced by mental health services in a time of austerity.

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