Consultant psychiatrists who retired prematurely in 1995 and 1996†

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Owing to the large and increasing number of vacant consultant posts in psychiatry, and the suspicion that premature retirement was an important cause of this problem, a questionnaire was sent to all consultants who were believed to have retired from their National Health Service (NHS) posts before their 65th birthday during 1995 or 1996. One hundred and forty-two (82%) of 173 questionnaires were returned. Responses to these indicated that disenchantment with some aspect of the previous Conservative Government's 'NHS Reforms' was a more important reason for retirement than ill health, a wish to devote more time to other interests, or even bed closures. Increasing bureaucracy and paperwork was a key factor for many.

Early in 1996, spurred by the rising number of unfilled consultant posts in psychiatry, the College and the Department of Health set up a joint working party to consider the causes of and possible solutions to the problem. The working party submitted its report *Medical Staffing in Mental Health* to Dr Graham Winyard, Medical Director of the NHS Executive, in November that year. One of the report's conclusions was that an unusually large number of consultants appeared to have taken early retirement in the previous two or three years. It therefore recommended that the College mount a survey of recently retired consultants in order to assess the scale of the problem and find out why so many consultants were retiring prematurely. The recommendation was accepted by the Department of Health and plans to carry out a survey, funded by the Department, were put in hand immediately.

Method

In November 1996 a letter was sent to the College's Deputy Regional Advisers throughout the UK asking them to provide, if they could, a comprehensive list of all consultants in their region who had "retired from their NHS posts before their 65th birthday since December 31st 1994". It was emphasised that consultants who had moved to an NHS post elsewhere should not be included, but those who had moved into private practice or retired on grounds of ill health should be. This request produced a list of 173 names and addresses after duplications and obvious errors had been eliminated.

In March 1997, a letter was sent (by R.E.K.) to these 173 psychiatrists explaining why the College was so concerned, asking them to complete a simple two-page questionnaire about the reasons underlying their decision to take early retirement, and promising that their replies would be treated in strict confidence. A second letter was sent to non-responders five weeks later.

Results

Questionnaires were returned by 142 (82%) of the 173, an unusually high response for a postal questionnaire. Unfortunately, 40 (28%) did not fulfil the defining criterion of retirement from the NHS in 1995–1996 before the age of 65. In most cases this was because they had retired a few months before 1 January 1995. Some sent long letters in reply but declined, for various reasons, to complete the questionnaire. A few turned out not to be psychiatrists (some trust personnel departments obviously had difficulty distinguishing psychiatrists from pathologists or paediatricians) and one or two young consultants had resigned, either to go abroad or to work outside the NHS, rather than retired. (With hindsight the entry criteria should have included resignation but this was not a possibility that had been foreseen.) There were therefore 102 valid responses and the analysis and commentary that follow refer to these 102. Forty-seven per cent had retired in 1995 and 51% in 1996. Thirty-three per cent had retired before the age of 55, and 11% before the age of 45 (see Table 1). Only 16% had formally retired early on grounds of ill health and only 37 (36%) had qualified for a

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Table 1. Age at retirement

Age	*n* (%)
30–39	3 (3)
40–44	8 (8)
45–49	11 (11)
50–54	11 (11)
55–59	37 (36)
60–64	30 (29)

40/80ths pension. (Full pension is 45/80ths.) The regions in which they had worked are shown in Table 2.

Premature retirements had occurred in every region except Northern Ireland, but it should be noted that two of the three Northern Irish questionnaires were not returned. The largest number of premature retirements were from the South Western Region (13), Wessex (11), North East Thames (10) and Scotland (10), whereas the regions with the largest number of unfilled consultant posts on 30 September 1996 were Scotland (52), the North Western Region (50), North East Thames (50) and Trent (42). This suggests that premature retirement may have made a major contribution to the overall vacancy rate in North East Thames and Scotland, but not in the North West or Trent (only two and four premature retirements, respectively). These regions may, however, have lost consultants as a result of transfers to other, better staffed areas.

The questionnaire offered seven possible reasons for premature retirement (plus an eighth 'other reasons' category) and asked respondents to indicate which of these seven had contributed to their decision to retire early and which was the single most important reason. The replies are summarised in Table 3. It is clear from these that disenchantment with some aspect of the Conservative Government's 'NHS Reforms' was a more important determinant for most people than poor health or simply a wish to devote more time to their families and other interests. It is also apparent that increasing bureaucracy and paperwork (cited by 70%) was more important than local bed closures (cited by only 37%), suggesting that the changing ethos and management of the NHS were more important than the running down of old institutions in favour of 'community care'. It is also clear, though, that many respondents felt that the seven reasons offered by the questionnaire failed to do justice to their particular circumstances. Seventy per cent cited 'other reasons' as contributing to their personal decision to retire early and 33%, twice as many as for any of the seven reasons offered by the questionnaire, cited these as their main motivation.

Those giving 'other reasons' were invited to describe these and a selection of their replies are shown, verbatim, in Appendix 1. Some gave reasons like increasingly difficult patients and fears for their personal safety, which we had not foreseen when designing the questionnaire. Others made it clear that they had always intended to retire early. But most simply wished to highlight some aspect of the profound cultural change embodied by the 'NHS Reforms' that they felt was not adequately captured by the broad categories offered by the questionnaire. The phrases and sentences in Appendix 1 paint a

Table 2. Regions in which retired consultants had worked

Region	Questionnaires sent out	Valid responses	Invalid responses	No response
East Anglia	9	7	0	2
Mersey	9	5	3	1
Oxford	8	4	0	4
South Western	17	13	3	1
West Midlands	6	5	1	0
North East Thames	22	10	8	4
North West Thames	13	5	4	4
South East Thames	6	4	1	1
South West Thames	6	5	0	1
Wessex	15	11	3	1
North Western	4	2	0	2
Northern	5	3	2	0
Trent	11	4	5	2
Yorkshire	11	6	5	0
Scotland	14	10	2	2
Wales	9	5	2	2
Northern Ireland	3	0	1	2
Special health authorities	5	3	0	2
Total	173	102	40	31

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Table 3. Reasons given for early retirement

	Contributory *n* (%)	Main reason *n* (%)
A wish to devote more time to hobbies or other interests	50 (49)	14 (14)
Ill health	24 (24)	12 (12)
Increasing work load due to:		
local bed closures	38 (37)	2
increasing bureaucracy and paperwork	71 (70)	6 (17)
staff shortages	52 (51)	6
Government policies for the care of the mentally ill	57 (56)	9 (9)
Interference by managers in clinical matters	53 (52)	10 (10)
Other reasons	71 (70)	34 (33)

sad picture of a group of men and women feeling increasingly overworked, under stress and unappreciated, who eventually decided that their working lives and their relationships with their patients had changed so much that they were not prepared to soldier on any longer. Some had specific fears of being involved in a homicide enquiry, some were irritated by 'fatuous form filling', some felt angry and humiliated by the decisions of purchasers or their own managers, most were simply fed-up and disillusioned.

The questionnaire also asked "What might have persuaded you not to take early retirement?", and a selection of the replies to this question are shown in Appendix 2. The most common reply was 'Nothing!', either because they had always intended to retire as early as possible or because they were alienated by the changes in their working lives. It is also clear that several respondents had specific objections to the policies of the Conservative administration and to the ethos of the internal market, and would probably not have left the NHS if the Government or its policies had changed. Others were clearly in conflict with their managers, medical or non-medical, or were angered by the decisions or attitudes of their purchasers. Some simply felt overworked and unappreciated and saw retirement as the only way of escaping from the pressures on them.

Over half (53%) of the 102 respondents said that they were now working, part-time or full-time, in private practice, and over a quarter (26%) said that they were still working, part-time or intermittently, for the NHS. Many of those who had moved into private practice commented how much they were enjoying working in this setting, and several emphasised that the main attraction was not the financial rewards but the opportunity it gave them to spend their time treating patients rather than attending endless meetings, filling-in forms and writing reports. It was also apparent that several of those who regarded themselves as still working for the NHS were working for Mental Health Review Tribunals or the Mental Health Act Commission, rather than working in a part-time or locum capacity for the NHS itself.

The questionnaire ended with an open invitation "Do you have any further comments?" This elicited many responses, a selection of which are shown or summarised in Appendix 3. On the whole, despite their poignancy, these comments merely elaborate on or expand themes and sentiments that were clearly expressed in response to previous questions. They do convey, though, a pervasive sense of sadness and even guilt over their decision to leave the NHS whose original ideals they had once committed themselves, to which they had devoted most of their working lives, and which they now perceived as failing both its patients and its staff.

Comment

The original request to the College's local manpower experts, the Deputy Regional Advisers, produced a list of 173 consultant psychiatrists believed to have retired from their NHS posts before their 65th birthdays in 1995 and 1996. Only 102 of those 173 had definitely done this, but it is likely that about three-quarters of the 32 non-respondents had also done so. As it is unlikely that many prematurely retiring consultants were overlooked, the total number of UK consultants retiring early in 1995 and 1996 is probably between 120 and 140, or 60–70 per year. It is clear that an important minority had always intended to retire early, and had long been encouraged to do so by the unique advantages of Mental Health Officer status. So the annual number of potentially avoidable premature retirements is almost certainly not higher than 50. This is not a large number compared with the total number of psychiatric consultant posts in the UK (3389 in September 1996) or the number of currently unfilled consultant posts (457 in September 1996). We do not know how long consultants have been retiring early at this rate, though it seems likely that numbers were equally high in 1992, 1993 and 1994, and there is no indication yet that the

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annual number is falling (this survey identified more early retirements in 1996 than in 1995). It may be, therefore, that there were about 250 potentially avoidable premature retirements in the five-year period from 1992 to 1996, and this is 55% of the currently unfilled posts. So early retirement is certainly an important cause of the present, alarmingly high number of vacant consultant posts, and possibly the major cause.

It is important not to lose sight of the fact that the raw material of this study consists entirely of written responses by recently retired psychiatrists to a self-report questionnaire. It is their account, their view of the events leading up to their decision to retire from their NHS posts and their colleagues and managers, medical and non-medical, might have taken a different view. In some cases other people might have regarded the departing consultant as a reactionary obstructing change, as lazy, as an indifferent clinician, or simply as a regrettable but unavoidable casualty of the urgent need for radical changes. Doubtless, not all those who retired early were mourned by their colleagues, or represented an important loss to local services. Even so, the overriding impression one gets from the results of this survey, and the written comments of the respondents summarised in the appendices, is that the NHS has lost a substantial number of able, conscientious, even dedicated men and women as a result of overloading them, ignoring or overriding their professional opinions, forcing them to devote precious time to what they regarded as pointless bureaucratic tasks and scorning their public service values. If there had been substantial numbers of newly trained psychiatrists waiting for consultant posts to become available, then the haemorrhage which these premature retirals represent could have been treated effectively by a rapid infusion of new blood. But there was not enough new blood available and, as a result, psychiatric services in several parts of the country are becoming exsanguinated.

What can be done to halt and, if possible, reverse this loss of precious expertise? It is unlikely that many of those who have already retired from the NHS can be persuaded to return, though some of the comments in Appendices 2 and 3 suggest that a change of political philosophy and the abandonment of the commercial ethos of the internal market may persuade a few to come back. A more important task is to consider what might be done to ensure that this flood of premature retirement does not continue in 1998 and 1999. Little can be done to lighten the clinical load on consultants. Patient expectations will continue to rise; the funding available to the NHS will continue to be tightly constrained; and psychiatrists, psychiatric nurses and clinical psychologists will remain in short supply. It is clear from the responses to the questionnaire, though, that heavy clinical responsibilities are not perceived by most consultants as the central problem. Interference by managers in clinical matters (cited by 52%) and, above all, increasing bureaucracy and paperwork (cited by 70%) are at least as important. For a variety of reasons which have little to do with psychiatric services, NHS managers are likely to be less confrontational in future than some have been in the recent past; and many of the bureaucratic procedures which most psychiatrists regard as a waste of valuable clinical time could easily be abolished or simplified at no cost at all. Fewer committee meetings and working parties which achieve nothing, the abolition of supervision registers, of managers' reviews and of the compulsory homicide enquiries which hang like the sword of Damocles over every urban community psychiatrist, and a simplification of the bureaucracy of the Care Programme Approach would go a long way towards restoring the morale of psychiatrists as well as leaving them more time to treat their most needy patients.

Appendix 1. Notable 'other reasons' for early retirement given by respondents

I had decided to retire at 60 many years ago.

Psychiatry was among the specialities (surprisingly) offered early retirement in Scotland with pension as if at 65. This was too tempting to refuse.

A consultant colleague committed suicide in 1994. I did not want to be next.

A recurring feeling that I was failing despite working long hours.

I had no wish to be 'crucified' in a future hospital enquiry into a suicide/homicide.

Persistent awareness of a disaster about to happen at any time . . . I realised it was only a matter of time before I was in the dock (i.e. a homicide enquiry) despite all my best efforts.

Stress, stress, stress.

I feel I let a patient down . . . with serious consequences.

I was tired. I had nothing left to give.

I was unable to give enough time to many needy people because of imposed changes in practice.

Increasing fear for personal safety.

The level of violence against staff . . . and the level of violence committed by my patients.

The night work got too demanding.

Unable to meet the conflicting demands of NHS work and university work.

A total disregard for the views of the clinical team in planning services.

An impossible medical director.

Appointment of a colleague as clinical director for whom I had no respect.

I was always in cross fire between medical colleagues and non-medical managers.

I was deeply disenchanted by the fact that I didn't have any influence over long term or day to day plans, though ultimately 'I carried the can'.

Only negative feedback from managers.

The main reason was a feeling of being unappreciated/unsupported by management – an atmosphere of alienation – 'us and them'.

Appalling attitude (hostility and grossly inadequate funding) to psychiatry of the purchasers.

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Dishonesty of purchasers in hidden cuts to services.
Purchasers set unrealistic demands on the Trust and the Trust in turn expects these demands to be met by the consultants.
I grew tired of fatuous form filling which seemed designed to produce some kind of tenuous fossil record of clinical practice for inspection . . .
Invaluable times are wasted in filling up useless forms and documentations.
Asset stripping of psychiatric department by acute unit.
I could work less hours and earn nearly four times as much doing clinical work only, which is what I always wanted to do.
I was no longer able to practise psychiatry properly. There were not even minimally adequate facilities to look after patients in the way which they merited.
I was not allowed to carry on seeing my old patients because they came from an area which did not have a contract with our Trust.
Increasingly difficult patients – drug induced psychotic states, antisocial personality disorders.
Main reason was the birth of my twins. I explored the possibility of returning part time initially but management was singularly unhelpful and obstructive.
Requirement to identify year after year cost savings and make staff in my department redundant to save L.S.D.

Appendix 2. Representative replies to the question "What might have persuaded you not to take early retirement?"

I had always planned to give up full time work when able to claim maximum pension.
I had planned for 20 years to retire at 57/58.
People entitled to MHO (Mental Health Officer) status can retire at 55 and I personally see no real virtue in continuing to work full time once full pension has been achieved.
A change of Government.
Change of Government at 1992 election.
A rebirth of Nye Bevan's NHS.
By 1995 – nothing.
Nobody and nothing.
Nothing will now induce me to return.
Nothing. The situation in inner London was, and still is, . . . so awful.
A dynamic service orientated management capable of taking us into the 21st century.
A Government that did not demand we made bricks without straw.
An end to the internal market ethos.
A 'Product Champion' in the Health Authority for learning disability.
Less arrogant and assertive management.
Managers and purchasers who could do the job they are supposed to.
Support from my medical and non-medical managers.
The Chief Executive and Medical Director retiring.
Understanding and respect from managers and purchasers.
A less demanding work load.
A stop to bed reductions.
A substantive consultant partner (rather than a series of locums) would have delayed my going.
If the NHS allowed me to work full time clinically and I could give patients what I felt they needed quickly.
Not having to be legally responsible for the violence of untreatable patients.

Appendix 3. Illustrative replies to the final question "Do you have any further comments?"

I had always planned to go by 60.
Retirement is wonderful!
God knows how those in London survive.
I was probably close to burn out. Support and supervision arrangements for consultants are nearly universally inadequate.
My successor, a young man, is finding the job unbearable.
We need to remind the Government that unrealistic goals, matched against limited resources, will result in demotivated staff, not more effective services.
When I was first appointed to my consultant post I placed a card in the bottom of my in-tray. It read 'How to avoid burnout – set realistic goals for yourself, your team, the organisation'. I rarely reached the bottom of my in-tray to remind myself of this.
I left the NHS for the private sector because I could practise psychiatry in the way I wished in a much happier place.
It has been a tremendous relief to have left my NHS post. I enjoy the freedom to undertake now, for the first time, some private practice at a friendly hospital.
It is delightful to be able to pursue the craft as it was taught to me: no regrets (from a consultant who had moved into private practice).
As a life long socialist I often feel I have betrayed my principles (by moving into independent practice).
I believe that, in the true sense, NHS ideals remain the best in the world.
If the National Health Service does again become truly that I may well return one day, despite the cut in salary.
A rotating sabbatical could help rejuvenate consultants.
I fear that general psychiatry is in great danger of being relegated to scapegoated 'mad doctoring'.
It (redundancy) has worked out to my financial advantage but was clearly a waste of NHS money and resource.
It is sad that many of my younger colleagues know the exact date of their retirement – several years ahead.
People becoming machines and 'goodwill' in decline.
We need to continue to point out to the Department of Health that the UK has far less consultant psychiatrist posts than other countries which provide community care.
There was little cohesion amongst clinical colleagues, rather there was much 'empire building' . . . management was quite supportive.

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