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THE OLDER PSYCHIATRIST AND RETIREMENT

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ABSTRACT

Objective. To determine the clinical practices, retirement plans and post-retirement professional activities of older psychiatrists, comparing retirees with working psychiatrists.

Design. Postal survey.

Participants. All Fellows of the Royal Australian and New Zealand College of Psychiatrists aged 55 years and over, resident in Australia or New Zealand. Of 468 eligible subjects, 281 (60%) participated.

Main outcome measures. Location and type of psychiatric practice; hours of work; retirement plans; anticipated and actual retirement criteria; anticipated and actual post-retirement professional activities; self-rated health.

Results. Working psychiatrists comprised 79% of the sample, being significantly younger (mean 63.8 years) than retirees (mean 72.3 years, $p < 0.001$). Over 62% of respondents worked principally in general psychiatry. Working psychiatrists were mainly in private practice (61%) and retirees had been in public psychiatry (53%, $p < 0.001$). Working psychiatrists worked about 41 hours/week, 98 (49%) having reduced their hours in the previous 5 years. Retirement plans had been commenced by 124 (61%). Fatigue (27%) and memory impairment (10%) were reported as age-related changes adversely affecting work capacity, raising concerns of competence. Working psychiatrists more often anticipated deteriorating health ($p < 0.001$) and family/personal reasons ($p < 0.01$) as retirement criteria and anticipated involvement in a significantly higher number of post-retirement professional activities than retirees reported ($p < 0.001$). Retirees rated themselves in significantly poorer health than working psychiatrists ($p < 0.001$), even when age was partialled out ($p < 0.001$).

Conclusions. Most older psychiatrists gradually retire by reducing work hours and developing new interests. The majority of retirees retain involvement in professional activities, but substantially less than anticipated by those still working.

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INTRODUCTION

Retirement has been defined as withdrawal from paid employment, which in many countries is now mandatory at a fixed age except for the self-employed (Mulley, 1995). While the decision to retire may be a difficult one, the trend in Australia over the last 20 years has been towards early retirement. Increasing numbers of older workers, particularly women, work part-time and often in a new career, and would be best described as semi-retired (Rosenman, 1994). The extent to which psychiatrists are following this pattern is unknown.

Psychiatry lacks clear guidelines for retirement beyond the need for competence to maintain professional standards. As in many professions, the psychiatrist is generally able to choose when to retire instead of facing compulsory retirement. To some degree, maintenance of practice standards programmes (MOPS), as recently introduced by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), are addressing the competency question, although they are unlikely to result in the early detection of the impaired psychiatrist.

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Issues in retirement planning such as practice closure, financial needs and post-retirement professional roles are infrequently raised. Previous reports on the retirement of psychiatrists and physicians suggest that they may have particular difficulties in deciding whether to retire due to financial concerns, fears about loss of professional role and worth, commitments to patients and denial of waning competence (Grauer and Campbell, 1983; Kaplan and Rothman, 1986; Berthelsdorf, 1992; Hurwitz, 1992). The psychological adaptations required by physicians to cope in their professional role may increase their vulnerability to the effects of the ageing process (Sadavoy, 1994).

The aim of this report is to examine the attitudes and experiences of older psychiatrists with regard to clinical practice, retirement and post-retirement professional activities, by comparing responses of working and retired psychiatrists.

METHODS

The sample comprised all Fellows of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) aged 55 years and over and resident in Australia or New Zealand, who were part of a larger survey of RANZCP Fellows. RANZCP cooperation was obtained following a review of the research proposal by the RANZCP Board of Research and approval was obtained from the University of New South Wales Ethics Committee. To maintain confidentiality, only broad demographic data about the sample—sex, RANZCP Branch membership (ie New Zealand or State/Territory of Australia) and the number of Fellows who were classified by the RANZCP as being 'retired' or 'active'—were supplied to the investigators. The 'retired' list included three groups of Fellows—those aged 65 years and over who had been Fellows for 30 years or more; those who were retired from practice (defined as working two sessions per week or less); and Honorary Fellows. Fellows classified as 'retired' do not have to pay College subscriptions. Very few retired psychiatrists remove themselves from the list of RANZCP Fellows (RANZCP, personal communication). The anonymous surveys were mailed by the RANZCP in August 1995 with a reminder letter being sent a month later.

Two versions of the survey questionnaire were devised, one for 'active' Fellows, the other for 'retired' Fellows. Both versions contained items pertaining to age; sex; ethnicity; RANZCP Branch membership; professional qualifications; length, location and type of clinical practice; hours of work; recertification of psychiatrists; criteria and plans for retirement; proposed post-retirement activities; and self-rated health. In addition, Fellows in 'active' practice were asked to comment upon the benefits and drawbacks of their current age and experience for their clinical practice.

The data were analysed using the SPSS statistical package. Categorical variables were analysed using chi-square analysis (with Yates' continuity correction for all 2×2 analyses) and continuous variables by independent sample Student's t-tests, using separate- and pooled-variance tests as appropriate. An analysis of covariance (ANCOVA) was also performed, with age as the covariate. Open-ended responses were categorized into broad groupings *post hoc* by consensus between two of the investigators (SW and BD). All analyses were two-tailed and alpha was set at 0.05.

RESULTS

Of the 468 RANZCP psychiatrists aged 55 years and over who were surveyed, responses were received from 281 (60%), 231 males and 50 females. Responders and non-responders did not significantly differ in terms of sex, College branch membership or the proportion on the 'active' or 'retired' list. There were 223 respondents (79% of all respondents) who were still working in psychiatric practice. These 'working' psychiatrists included 203 on the RANZCP 'active' list and 20 on the nominal 'retired' list. Fifty-eight respondents (21%) were actually retired from practice, the length of retirement ranging from less than a year to 29 years (mean 7.6 years, median 6.5 years). Their mean age at retirement was 64.9 years (SD 7.3).

Ages ranged from 55 to 87 years (mean 65.5 years, $SD = 7.5$), with the retired psychiatrists being significantly older (mean 72.3, years, $SD = 7.2$) than the working psychiatrists (mean 63.8 years, $SD = 6.5$; $t = -8.63$; $df = 277$, $p < 0.001$). Eighty five per cent ($n = 238$) were married or in de facto relationships, 7% (19) were separated/divorced, 6% (17) were widowed and 2% (6) were single. The retired psychiatrists did not differ significantly from the working psychiatrists in terms of sex ($\chi^2 = 0.71$, $df = 1$, NS),

marital status ($\chi^2 = 4.05$, df $= 3$, NS) or racial background ($\chi^2 = 5.21$, d$f = 3$, NS).

Twenty-three responders (8%; $N = 273$) indicated that they had commenced training before 1950 (the earliest being in 1934!) and 98 (36%) before 1960. Psychiatric qualifications had been held for at least 25 years by 153 responders (58%; $N = 263$) and for at least 20 years by 208 respondents (79%). In addition to RANZCP Fellowship, 140 respondents held the Diploma of Psychological Medicine, 71 were Members and 29 were Fellows of the Royal College of Psychiatrists and 32 had higher medical degrees. They also held a wide range of other psychiatric, medical and non-medical qualifications. When asked whether the RANZCP should be involved in the reaccreditation of psychiatrists, 200 (72%; $N = 276$) were in agreement. 'Substantial breaks' in psychiatric practice had been taken during their careers by 61 respondents (22%; $N = 277$), with the main reasons being extended travel/recreation (43%) and other medical work (24%). Six female psychiatrists had taken maternity leave.

Over 62% of respondents worked principally in general psychiatry ($n = 173$), 14% in psychotherapy ($n = 39$) and nearly 10% in family, child and adolescent psychiatry ($n = 27$). When the respondents' three main fields of psychiatric practice were combined, 79% worked to some extent in general psychiatry ($n = 219$), 42% in psychotherapy ($n = 117$), 24% in family, child and adolescent psychiatry ($n = 68$), 22% in administration ($n = 60$), 17% in forensic psychiatry ($n = 48$), 14% in consultation–liaison psychiatry ($n = 39$), 12% in community psychiatry ($n = 33$), and 10% in psychogeriatrics ($n = 29$). There were no significant differences between working and retired psychiatrists in their fields of psychiatric practice ($\chi^2 = 9.59$, d$f = 10$, NS).

The principal and overall practice locations are listed in Table 1. Significant differences were found between retired and working psychiatrists on their principal location of practice, with retired psychiatrists predominantly based in public psychiatry, ie general hospital, psychiatric hospital or community health (53%), and working psychiatrists in private practice (61%; $\chi^2 = 14.04$, d$f = 1$, $p < 0.001$). There was a trend towards later retirement in those working principally in private practice ($t = -1.87$, d$f = 45$, $p = 0.067$).

Of the 223 working psychiatrists, only the 203 respondents on the 'active' list were questioned about work hours. On average, the psychiatrists were working just over 41 hours per week (range 5–84) including over 4 hours per week at home. Twenty-four psychiatrists (12%) were working 20 hours/week or less, with six (3%) working 10 hours/week or less. There were no significant sex differences on working hours. Ninety-eight respondents reported that they had reduced their working hours in the previous 5 years by an average of about $10\frac{1}{2}$ hours per week. The main reasons for reducing work hours were change of lifestyle or development of other interests (43%), burnout/fatigue (21%), age (15%), semi-retirement (14%) and ill health (11%).

When asked whether they intended to retire, 33 (17%; $N = 198$) respondents indicated that they did *not* anticipate retiring. Retirement plans had been commenced by 124 respondents (61%). These plans included financial planning (56%; $N = 121$), a reduction in workload (41%) and acquiring hobbies and other interests (35%). Some of the ways that working psychiatrists proposed to eventually close their practices included a progressive reduction in work hours (48%; $N = 182$), arranging for other colleagues to take over their practice (26%), not accepting new referrals (14%)

Table 1. Locations of practice

Location of practice	Principal location of practice		All practice locations	
	Working ($N = 220$†)	Retired ($N = 58$)	Working ($N = 220$†)	Retired ($N = 58$)
Private practice	133 (61%)	17 (29%)	168 (76%)	31 (53%)
General hospital	16 (7%)	10 (17%)	74 (34%)	28 (48%)
Psychiatric hospital	33 (15%)	16 (28%)	72 (33%)	34 (59%)
Community health	19 (9%)	5 (9%)	45 (21%)	13 (22%)
University	14 (6%)	6 (10%)	34 (16%)	13 (22%)
Other	5 (2%)	4 (7%)	19 (9%)	12 (21%)

†No response $n = 3$.

and retirement from public service (14%). The retired psychiatrists had closed their practices by retiring from the public service (42%; $N = 53$), arranging for other colleagues to take over their practice (30%), working to a set retirement date (15%), progressively reducing their work hours (13%) and not accepting new referrals (13%). The retired psychiatrists were asked to comment on preparing for retirement and the main suggestions were to develop interests outside of work (36%; $N = 50$), to seek financial advice (20%), to reduce work gradually (16%) and to make preparations to minimize the trauma of loss of professional role (14%).

The anticipated criteria for retirement of the working psychiatrists and the actual retirement criteria of the retired psychiatrists are listed in Table 2. Comparisons revealed that working psychiatrists were significantly more likely to anticipate deteriorating health ($\chi^2 = 13.70$, $df = 1$, $p < 0.001$) and family/personal reasons ($\chi^2 = 6.76$, $df = 1, p < 0.01$) as criteria for retirement than were reported by the retired psychiatrists. The working psychiatrists anticipated a significantly larger number of potential criteria for retirement (mean 2.3 criteria per psychiatrist, SD = 1.0) than the retired psychiatrists reported (mean 1.9, SD = 0.8; $t = 3.82$, $df = 118$, $p < 0.001$).

The anticipated post-retirement professional activities of the working psychiatrists and the actual continuing professional activities of the retired psychiatrists are listed in Table 3. Working psychiatrists were significantly more likely to anticipate involvement in writing ($\chi^2 = 9.09$, $df = 1, p < 0.01$), consultancy ($\chi^2 = 9.86$, $df = 1$, $p < 0.01$), mentorship ($\chi^2 = 16.89$, $df = 1$, $p < 0.001$) and attendance at professional meetings ($\chi^2 = 12.46$, $df = 1, p < 0.001$) than was occurring in the retired group. This is further illustrated by the significantly higher number of post-retirement professional activities anticipated by the working psychiatrists (2.6 per psychiatrist, SD = 1.7) than retired psychiatrists were actually involved with (1.7 per psychiatrist, SD = 1.4; $t = 3.96$, $df = 106$, $p < 0.001$). Only three of the retired psychiatrists believed that the RANZCP needed to provide any additional services for them.

On a measure of self-rated health, 43% of working psychiatrists ($n = 94$) rated their health as excellent, 47% as good (103), 10% as fair (23) and only one as poor. When compared to working psychiatrists, retirees rated themselves in significantly poorer health ($\chi^2 = 40.09$, $df = 3$, $p < 0.001$), with only 14% ($n = 8$) rating their health as excellent, 48% as good (28), 26% as fair (15) and 12% as poor (7). An analysis of covariance between self-rated health and age was then undertaken to determine whether the poorer health of the retirees was due to their age. Even after age was partialled out, the retirees had poorer health than those still working ($F(1, 276) = 16.10$, $p < 0.001$).

The working psychiatrists were asked about the benefits and drawbacks of their age and experience to their work. The perceived benefits of age included credibility and respect from patients or colleagues (22%, $n = 42$), a wider, more mature life perspective (21%, $n = 40$) and an increased ability to empathise and communicate with older

Table 2. Criteria for retirement

Criteria	Working psychiatrists anticipated criteria ($N = 213$)†	Retired psychiatrists actual criteria ($N = 58$)
Age	123 (58%)	36 (62%)
Finance	96 (45%)	22 (38%)
Health	142 (67%)	22 (38%)**
Family/personal	87 (41%)	12 (21%)*
Career change	19 (9%)	7 (12%)
Other	21 (10%)	9 (16%)
Don't know	6 (3%)	0 (0%)

Note: Multiple responses allowed.
* $p < 0.01$; ** $p < 0.001$.
†No response $n = 10$.

Table 3. Anticipated vs actual professional activities after retirement

Professional activities	Working psychiatrists anticipated involvement ($N = 220$)†	Retired psychiatrists actual involvement ($N = 58$)
Read professional journal	131 (60%)	43 (74%)
Research	34 (16%)	7 (12%)
Writing	78 (36%)	8 (14%)*
Consultancy	106 (48%)	14 (24%)*
Mentorship	93 (42%)	7 (12%)**
Attend professional meetings	96 (44%)	10 (17%)**
College office-bearer	12 (6%)	2 (3%)
Other, eg teaching, supervision	25 (11%)	10 (17%)
None	30 (14%)	14 (24%)

Note: Multiple responses allowed.
* $p < 0.01$; ** $p < 0.001$.
† No response $n = 3$.

patients (14%, $n = 27$). In contrast, 21% (40) indicated that their age was of no benefit to their practice. The major benefit of experience was greater confidence/competence (49%, $n = 90$). Although 29% ($n = 57$) indicated that there were no drawbacks due to age, 27% ($n = 52$) identified fatigue, tiredness or lack of energy, 13% (26) were less able to cope with work-related demands, 12% (23) had difficulty in maintaining their knowledge base, 10% (19) had poor memory and 7% (14) poor physical health.

DISCUSSION

To our knowledge, this is the first survey of the attitudes and experiences of older psychiatrists with regard to clinical practice, retirement and post-retirement professional activities. As there was a similar and adequate response rate for both working and retired psychiatrists and very few retired psychiatrists relinquish contact with the RANZCP, we believe that potential biases in the sampling frame were minimized.

The majority of the older psychiatrists were still working. Few envisaged completely severing professional ties, as can be noted by their anticipation of being involved in an extensive range of post-retirement professional activities. Although 17% stated that they did not intend to retire, this is less than reported in a survey of 58 physicians aged 65 years and over where two-thirds made similar claims (Grauer and Campbell, 1983). Still, our findings suggest that a significant number of older psychiatrists have an unwillingness to consider retirement.

It has been suggested that professional development for a person in their mid-fifties to mid-sixties may include decisions regarding continued career growth and retirement planning. These may be influenced by personal health concerns, adjustments to changing roles in marital and professional life, the ability to come to terms with life choices and to become a more insightful teacher and role model (Hazzard, 1994). Over 60% of the psychiatrists had commenced retirement planning, with many gradually reducing their hours, often searching for a different balance between career, family and hobbies. Health concerns, lifestyle changes and burnout were most frequently cited as precipitants for their evolving semi-retirement.

The trend towards later retirement in private practice may suggest that the retirement process is more complicated for these psychiatrists. One barrier in private practice is the need to find someone to take over the practice, for example, as one 74-year-old commented, ‘Aim at “retirement” was to slow down ... however my younger colleague died, others left for the city’, while a 65-year-old stated, ‘I hope for a colleague to turn up and take over’. In contrast, the public practice psychiatrist may regard the mental health service employer as being responsible for finding a replacement, particularly as mandatory retirement at age 65 has been the rule in most parts of Australia and New Zealand until recent years.

A second barrier to retirement is financial security. While financial planning was the most frequently cited retirement preparation, this was largely noted by public sector psychiatrists who were contributing to superannuation funds. The psychiatrist in private practice is required to take a more active role in financial planning. Where this has been neglected, financial concerns have been noted to delay retirement decisions in older physicians (Grauer and Campbell, 1983). As one 65-year-old commented, ‘I see too many doctors in private practice who live up to every penny of their income and then can’t afford to stop work when they clearly should’.

Retirement may be more intricate for psychotherapists, most of whom are in private practice. While many reported that they would not take on long-term cases, this may not be easily achieved. Furthermore, psychotherapists may fear that unexpected interruptions to therapy due to their own ill health could adversely affect their patients and consequently may continue working when unwell. This may affect the efficacy of therapy through countertransference reactions (Kaplan and Rothman, 1986). As one psychotherapist noted ‘I don’t like the idea of letting (patients) down!’. It has been recommended that ageing psychotherapists should plan for their own deaths by suggesting referral sources to their patients (Eissler, 1977).

One of the limitations of this survey was that the question of competency was not specifically addressed. However, nearly three-quarters of the sample believed that the RANZCP should be involved in the reaccreditation of psychiatrists. Many reported that their competence was at a peak due to their experience, for example, from a 67-year-old, ‘I believe my practice is probably of a higher standard than at any other time’. Other benefits, attributed mainly to the ageing process, included greater credibility and respect

from patients and/or colleagues, a wider, more mature life perspective and an increased ability to empathise and communicate with older patients. For psychiatrists, in contrast to some medical specialties, these benefits may outweigh any drawbacks associated with increasing age.

Some psychiatrists identified impairments in their own health as being a drawback to work. Of concern, over a quarter reported fatigue and 10% reported memory difficulties having an effect on their work. It was unclear whether these difficulties were affecting their competence to practice or plans to retire. Several respondents commented that the profession required some more formal mechanism to monitor the competence of psychiatrists. Whether the MOPS programme is capable of delivering such monitoring remains to be seen. Sadavoy (1994) has suggested that there is a need for a programme to evaluate mental competence and provide support and therapy for impaired physicians identified in peer assessment processes such as MOPS.

The retirees reported fewer reasons for retirement and were significantly less involved in post-retirement professional activities than anticipated by the working psychiatrists. This may be due to their poorer health, although it is possible that there were cohort differences between the retirees and working psychiatrists, as noted by the significant differences in practice location, which could determine their reasons for retirement and post-retirement activities. Yet, apart from age, there were no significant differences between the groups on demographic variables or fields of psychiatric practice. Despite their poorer health, it is interesting that retirees identified ill health less frequently as a reason for their retirement than had been anticipated by the working psychiatrists. Hopefully, the lack of involvement in professional activities indicates that retirees have developed sufficient non-professional interests to occupy their time, but this was not specifically covered in the survey. Of interest, the main suggestion that retirees had for working psychiatrists about preparing or retirement was to develop interests outside of work. This dilemma is typified by the comment from one 75-year-old, 'I am at a loss as to how to arrange to occupy my time when eventually I cease working'.

Approximately one-third of RANZCP Fellows are 55 years of age or older. In the United States the potential needs of the older psychiatrist have been recognized by the APA Council on Aging, which has established a Committee on the Senior Psychiatrist which first met in 1993. The Committee was formed to respond to issues relevant to older APA members including alterations of practice patterns and styles associated with ageing, pre-retirement planning, retirement and post-retirement activities (APA, 1994). This may be an approach that could be considered by the RANZCP and other similar professional bodies, although it is of interest that only three retired psychiatrists wanted more from the College.

Although health, lifestyle, retirement planning and post-retirement activities were broadly covered in this survey, more detailed longitudinal information is required which may be best obtained through individual interviews of older psychiatrists or focus groups. In particular, the barriers to retirement in private practice and the issue of competence of practice need to be explored. Further analysis of our larger survey will also allow comparisons between young and old psychiatrists on some of these issues.

In conclusion, the majority of older psychiatrists were still involved in busy careers, although many were reducing their work hours and planning a gradual retirement. Retirees were in significantly poorer health but the majority maintained an interest in professional activities, albeit with less involvement than anticipated by working psychiatrists.

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