PRACTICE OBSERVED

Practice Research

General practitioners' retirement plans and what influences them

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Abstract

The results of a study of the attitudes of 197 general practitioners aged 55 and over towards retirement and their plans for retirement are reported. Few wished to retire very early, and only a further 40% definitely planned a clean break from practice. Nearly half planned on taking "24 hour retirement," even though most (78%) will be entitled to full pension rights. Job satisfaction and health were the most important factors influencing the timing of the retirement. Seventy seven per cent thought that there should be no formal retirement policy, 79% wanted no compulsory retirement age, and 80% wanted no further controls or safeguards directed at older practising general practitioners. Half of the general practitioners in the sample were not looking forward to retirement.

Personal discussions with respondents aged 65 and over suggested that there are many older general practitioners who plan to practise for some time, who feel that they will know when the time has come to stop, but who often express the hope that they may "die in harness." A large proportion of older doctors are in singlehanded practice. In view of this, and also of the evidence from North America which suggests that older doctors may practise inferior medicine, it is thought that the ability of such general practitioners to evaluate their competence should be studied by methods such as peer assessment techniques.

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Introduction

Whether general practitioners retire early, late, or at an age that is regarded as conventional (65 years) has important implications for manpower planning—for example, in connection with the demand for and establishment of vocational training schemes. With the exception of a survey that was limited to inner London, little appears to have been established about general practitioners' retirement plans and the factors that influence these. Indeed, the only relevant study of retirement intentions and related attitudes of which we know was restricted to anaesthetists in Yorkshire.

Older medical practitioners in North America were found to be less successful on measures of clinical performance[1] and there are suggestions that in the United Kingdom older doctors are less likely to participate in continuing medical education. Coupled with the fact that 29% of practising general practitioners in the UK aged 65 and over are in singlehanded practice, compared with 14% overall (Department of Health and Social Security, Statistics and Research Section, personal communication, 1984[2] and thus not receiving daily informal "peer review,"[3] this may cause concern about older general practitioners in the UK. It would therefore be useful to know about the retirement plans of these doctors and what influences these plans.

A study was undertaken which explored the factors which general practitioners who are nearing conventional retirement age (or who had passed this) perceived to influence them towards earlier or later retirement. Then the retirement intentions of a national sample of such general practitioners were examined.

Method

Exploratory personal interviews were conducted by a medically qualified interviewer (MR) with a sample of 25 general practitioners aged 55 and over from two National Health Service regions, one primarily urban (North East Thames) and the other primarily rural (East Anglia). From these interviews a structured interview schedule was constructed (this covered retirement intentions and factors which the doctors said influenced these intentions

held views concerning formal retirement policies consistent with their position as self employed professionals. 77% said that there should not be a formal retirement policy for general practitioners (though the younger doctors were less sure about this than their older colleagues), 79% wanted no compulsory retirement age, and 80% wanted no further formal controls, safeguards, or assessments directed at older practising doctors. In the main these doctors thought that partners and patients were the best judges of competence. Generally, those who favoured formal safeguards (20%) suggested that they should consist of internal (within the profession) voluntary audits, that the results should be confidential, and that there should be no disciplinary action. Three quarters thought that the present system of safeguards was adequate.

The older general practitioners—To explore further the circumstances of general practitioners who were 65 and over a further 25 were selected for a personal interview. Sixteen (64%) were contacted and interviewed. Though no additional issues emerged—and indeed the small number would not permit statistically valid generalisations to be made—the circumstances and attitudes of two general practitioners are described in the appendix.

Classification of retirement intentions—From the data provided in the interview respondents can generally be regarded as falling into one of four categories: (*a*) those who have "had enough" and want to retire early or soon ("want out soon"), (*b*) those who will continue working for some time but then break their ties completely with medicine when they do retire, probably at 65 ("clean break"), (*c*) those who want retirement to be gradual over an extended period of time ("gradual"), (*d*) those who never want to retire ("never"). The group who "want out soon" is characterised by statements concerning a lack of job satisfaction: "I'm getting tired and not enjoying my work as much as I used to", "I feel drained and need to recuperate." The "clean breakers" more often mentioned family and non-job matters: "I'd like to devote my retirement to something entirely different", "People who retire live longer." Those who want a "gradual" approach to retirement as well as those who plan "never" to retire emphasised the value and experience of the older general practitioner, that they know of no other way of life, and—often—that patients have asked them not to retire.

Not unexpectedly, there is an association between this classification of retirement intention and age. Table V shows the distribution of the 189 doctors whom it was possible to classify. The retirement intentions are reflected by differing attitudes towards the possible introduction of a formal retirement policy. None of the "want out soon" or "never" groups favoured such a policy; 8% of the "gradual" group wanted one, but 49% of the "clean break" group would like this to be introduced.

TABLE V.—*Classification of retirement intention by age.* *%

Classification of retirement intention (see text)	Present age: 55-60 (n = 81)	61-65 (n = 24)	66+ (n = 15)	All respondents (n = 189)
Want out soon	1	0	0	1
Clean break	46	42	7	38
Gradual	49	42	57	48
Never	4	10	34	11

Discussion

For almost all general practitioners, general practice is a lifetime career, almost always spent in the same place. For many, their only medical activity consists of providing care for the patients on their NHS list, many also devote their whole life to their practice, having few if any outside interests. Retirement thus becomes a difficult, complicated, and sensitive issue, with many idiosyncratic approaches to and arrangements for it.

It is not surprising therefore that general practitioners often cannot be specific about their retirement plans—especially planning the date. The findings of this study suggest that nearly half of general practitioners can be expected to take 24 hour retirement and continue practising the reduced commitments—very few plan only to stop after hours cover, for example. About half will make a clean break of their retirement, few a few per cent at most doing so some years earlier than age 65. All this indicates a substantial continuation of the present position, whereby 5% of the principals in general practice in Britain are over the age of 65 (DHSS Statistics and Research Section (SR1A), personal communication, 1984). Only a few of the respondents in this study were women, however. By October 1983 37% of general practitioner trainees were women (DHSS (SR1A), General medical services: some basic statistics, 1984). If women's intentions of retirement are different from men's they will not be reflected in this study.

Although the need for income and the possibility of poor health were important in influencing general practitioners to think of retiring later or earlier (respectively), job satisfaction or lack of it had the most influence. Thus many wished to "die in harness" and quoted their perceptions of their patients urging them not to retire; they were horrified at the prospect of compulsory retirement.

It is of course open to discussion how accurate these perceptions are and how appropriate the aspirations, which sometimes seem more doctor oriented than patient oriented—particularly when nearly half of our respondents reported that they did not look forward to retirement. Whether it is in the interests of patients that their general practitioner should "die in harness," especially if single handed, is debatable given the evidence, for example, that older physicians are likely to practise inferior medicine. Unreality is most evident when general practitioners were asked about the desirability of additional safeguards regarding the competence of older general practitioners: few were keen on this, and even the fifth of the respondents who were, did not want the safeguards to be enforceable.

We were told repeatedly that general practitioners must not be made to retire at a particular point but that they should be able to choose to continue to practise, and they should and would know when the time had come when they were no longer competent. In view of the relatively large number of general practitioners planning to work on after 65 it seems timely to test this hypothesis. Peer evaluation, possibly coupled with feedback from patients, should confirm whether or not older general practitioners are indeed able to evaluate their own broad competence.

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Appendix

Views of Dr A and Dr B on retirement

Dr A is 78 and has been in the same three partner rural practice for 50 years. The practice provides its own out of hours cover but uses a locum once a week. His views on retirement: "People vary greatly in terms of how they age. I'm still physically and mentally fit at 78; others are not at 58. I'm against retirement policies and a compulsory retirement age. Patients should be the ones to decide whether one continues. As long as they want to go on it's clear you're fulfilling a useful role." He has no retirement intentions. The previous incumbent partner was in practice for 68 years, but Dr A "does not intend to go on that long." He is not looking forward to retirement.

Dr B is 76 and has been in the same inner city practice for 36 years, which he joined after emigrating to the UK from Eastern Europe. He took 24 hour retirement at 72. The practice has three partners and uses a deputising service for nights and weekends. Dr B attends postgraduate meetings and reads "all the journals." He has no medical activities other than looking after his NHS list, and no interests outside medicine—"medicine is my hobby." His views on retirement: "Experience is more valuable than academic knowledge. General practice is like the stage—if the public want the actor he carries on. General practitioners are like judges—they get better as they accumulate more experience. But each doctor must be his own safeguard, you must know yourself and know when the time has come to retire. You must be honest with yourself or you might kill a patient." He is against retirement policies and compulsory retirement: "I know a lot of young doctors who are incompetent." He has no idea when he will retire completely. He will practise as long as patients continue to write him letters asking him not to retire. Although he has bought additional years of pension, he is not entitled to full pension. He feels fit and will carry on "as long as I am competent to do so."

Conducting personal interviews with a national sample of respondents face to face is expensive, yet postal questionnaires did not seem appropriate for collecting data on such a personal subject, and a poor response rate could be expected. A compromise method is the telephone interview. Though the telephone interview is probably not appropriate for identifying issues nor for discussing them in depth, it has been found reliable in surveying broadly the views and attitudes of general practitioners.[6] We therefore decided to collect primary data by means of national telephone interviews, supplementing these with personal interviews with an additional sample of local doctors aged 65 and over.

The national sample of doctors was drawn from the *Medical Directory* on the assumption that the age of doctors at qualification is 24. The directory gives only the date of qualification, not a doctor's age. We thus effectively excluded from the study any potential subjects who qualified much later than this. Pages of the directory were drawn at random, and the first general practitioner practising in Britain, 55 or older, was selected for the study. Twelve subjects were found on telephoning either not to be in practice or to be younger than 55, since the number was small they were replaced by further random selection, using the same method.

Thus 250 names were drawn for the national telephone interview study. For the personal interviews of older doctors a further 25 names of doctors aged 65 and over who were practising in the two NHS regions were selected at random from lists of such doctors provided by a medical mailing service, details being checked in the *Medical Directory*.

The interview covered the type of practice and premises, number of patients on the doctor's list, and number of partners, professional activities (other than providing care for patients on their NHS list), continuing medical education activities, current retirement plans, factors which influenced taking earlier or later retirement, attitudes towards aspects of possible retirement policies, and outside interests.

Results

Of the 250 doctors in the national sample, 28 were no longer practising, owing to retirement or death, and a further 24, who were understood still to be in practice, could not be reached for interview (often because of answering systems—the interviewer did not claim to be an emergency), and one doctor refused to be interviewed. The 197 general practitioners who were interviewed represent a 79% response rate. To achieve this a total of 786 telephone calls was made.

The mean age of the 197 respondents was 61·4 years, 43% were aged 55-60, 39% were 61-65, and the remaining 18% were over 65. Four per cent were women. Less than a third of the respondents reported that they were in "city" practices, roughly a third were in "small or large" towns, a third were in "semirural" practices, and 8% were in rural ones. Two thirds were in practices with 5000 to 10 000 patients, 18% were in smaller practices, and 16% were in larger ones. Six per cent of respondents were single handed, and 96% were unrestricted principals.

A comparison with statistics from the Department of Health and Social Security (DHSS, Statistics and Research Section (SR1A), personal communication, 1984; General medical services: some basic statistics, SR1A, 1984) suggests that women, singlehanded doctors, and very old doctors were underrepresented in the sample. For example, 8% of unrestricted principals aged 65 or over in Britain are women.

With the exception of short periods for national service almost all of the general practitioners had been in lengthy continuous practice in the same location. The average length of service in their present practice was 28 years, and the average continuous length of service was 32 years.

Professional activities—Table I shows the respondents' professional activities in addition to providing care for their NHS patients. Over a third of the doctors had no other activities. Table II shows where the respondents

TABLE I.—*Does your work include any activities other than providing primary care for your NHS list?*

Activity	*% Of general practitioners*
Industrial medicine	45
Private practice	17
Nursing home	13
Police surgeon	13
Medical training	10
Hospital sessions	7
Research	0
Other†	28
None	38

*More than one response was allowed.
†Includes, for example, medical examinations for insurance companies and the DHSS and medical services for sports teams, boarding schools, and homes for handicapped people.

TABLE II.—*"What do you rely on for continuing education?"*

	% Of general practitioners
Journals	99
Meetings and courses at postgraduate centres	83
Hospital consultants	16
Local medical societies	4
Informal medical meetings	1
Meetings with other practices	1
Other	11

reportedly obtain their continuing medical education. Journals and postgraduate centres were most frequently mentioned, but meetings with colleagues were little favoured. The journals included the *BMJ* 94%, the *Practitioner* 80%, *Update* 30%, the *Lancet* 25%, *Journal of the Royal College of General Practitioners* 6%, video and cassettes 5%, and free weeklies such as *GP* and *Pulse* 41%.

Retirement plans—The general practitioners were asked at what age they intended to retire and ideally at what age they would choose to retire. Only 55% of the sample responded unequivocally to the first question; the average "intended" retirement age was 63·1 years. Fifty seven per cent responded to the second question, and the average "ideal" retirement age was 64·9 years. Given the opportunity, 46% of the doctors would like to take "24 hour retirement" and then continue with reduced work loads. Indeed, 20% regarded themselves as having started to retire already. For reasons such as a desire to cut ties completely, pressure from younger partners, and being an singlehanded practice 40% indicated that they would not or could not take some sort of graduated retirement. In most cases (90%) retirement intentions were not written into respondents' partnership agreements. Most general practitioners in the sample (78%) will be entitled to full pension on retirement and most (78%) have purchased additional years to reach "full pension" status.

Factors influencing timing of retirement—The respondents were asked to identify factors that might influence them to retire earlier rather than later, and what might influence them to retire later rather than earlier. About 14% of the respondents could offer no reasons for each of these items: not the same 84% for each item, tables III and IV. Job satisfaction was the dominant influence. Lack of job satisfaction would lead to early retirement for just under half and continued job satisfaction would lead to later retirement for just over half. Poor health was the second factor that would contribute to early retirement, and then being needed by patients and financial reasons would contribute to delaying retirement. Several doctors expressed the wish to "die in harness." Many who expressed extreme reluctance to leave practice listed no interest but medicine when asked about their other activities. When the doctors were asked whether they looked forward to retirement 9% could not say, 42% were looking forward to it, but 49% were not. Those aged 60-65 were looking forward to retirement more than those who were 55-60 or those over 65.

Views on retirement policy—Most of the general practitioners in the sample

TABLE III.—*"What do you see as being the major factors which would influence you to retire earlier rather than later?"*

	% Of general practitioners
Lack of job satisfaction	42
Poor health	19
Not keeping abreast, not providing good service	11
To pursue other interests	8
Family	7
Changes in the law affecting pensioners retirement	1
Other	4
No answer	84

TABLE IV.—*"What do you see as being the major factors which might influence you to retire later rather than earlier?"*

	% Of general practitioners
Job satisfaction	55
Needed by patients	15
Money	13
Encouraged to stay by partners	5
Health	4
Giving good service	3
No other interests	1
Other	2
No answer	84

Questioning Practice

Chickenpox isolation: is it worth the trouble?

A mother writes the following letter to Dr J C Kavalier and asked his general practitioner and a community paediatrician to answer his question: Is isolation of children with chickenpox necessary?

Children who have chickenpox should be isolated for one week from the appearance of spots or until dry scabs have formed, the textbooks tell us. Some schools will not allow children back until all their spots have disappeared. But is isolation of children with chickenpox necessary? And is it effective?

Chickenpox is highly contagious. Over 85% of susceptible household contacts will catch the disease, 95% of American women of childbearing age have detectable antibody to varicella zoster virus. It is, however, a relatively mild disease, and few children develop serious complications. The idea behind isolating children with chickenpox is, I presume, to prevent others from catching the disease. The short period of infectivity before the appearance of the rash, however, often ensures that the child with chickenpox will have infected his classmates before he goes into isolation.

So what is being gained by our attempts to contain this endemic disease? Not much, I suspect. Plenty of well children with spots are spending plenty of time away from school. Head teachers are enforcing a policy of isolation, unaware of its futility. Perhaps a few children are escaping chickenpox, but is this a good thing? The main consequence of isolation may be to give the disease to more adults, who are more likely to become seriously ill and develop complications.

There are, of course, special problems for children who are immune compromised by disease or drugs. But it is probably more appropriate to keep these children away from chickenpox rather than try to keep chickenpox away from them. My suggestion is simple: children with chickenpox should be kept away from school only while they feel ill.—F C KAVALIER, St Paul's Road Medical Centre, London N1 2LJ.

1 Bortman RL, Vaughan VC, McKay RJ: *Nelson textbook of pediatrics*. 12th ed. Philadelphia: W B Saunders, 1983: 736.
2 Fleisher GR: Varicella and herpes zoster. In: Stanley JH, Dalgleish RG, Hunter PB: *Immunology in medical practice*. 2nd ed. New York: McGraw-Hill, 1983: 117.
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Dr George B Taylor—Dr Kavalier presents a reasonable argument, with which I am sure many practitioners agree. The isolation of children with an illness that is usually recognised only when the rash appears, yet is most infectious in the prodromal stage, is nonsense. The fact that chickenpox is a more serious illness for adults and can lead to the babs being infected if it is contracted by a pregnant woman means that all children should be exposed to the virus. The real problem is that society has an aversion to people with spots and an even greater one to children with itchy, flaky ones.

The answer, therefore, is education of the public, especially of those who have responsibility for children. Educating a section of the medical profession may also be needed.

If a population of children can grow up happy in the knowledge that it is better to have chickenpox at an early age and that it is not a reason for missing school this information will begin to percolate into "accepted wisdom." Doctors who have regular contact with schools should take every chance to educate the staff. They should also attempt to make it local policy that "spotty children" come to school if they are well. Every general practitioner should also provide this education when presented with cases of chickenpox or when asked to talk about infectious diseases to groups.—Guide Post Health Centre, Northumberland NE62 5RA.

1 Robertson J: *Household pediatrics*. London: Gresham, 1894.
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Dr Stuart Currie—For most of its victims chickenpox is a mild disease. It is infectious, being spread mainly by the respiratory tract. The degree of infectivity, however, is not as great as, for example, in measles, and about half the children who have been in contact fail to get the disease.

Like most other exanthemata that are spread by the respiratory tract, chickenpox is also probably infectious a day or two before the eruption appears. The eruption is usually seen for the first time when the child is undressing for bed at night rather than in the morning—that is, in older children after a day at school. Only the vesicle fluid is contagious, not the skin lesions. By the time they have scabbed the vesicles are no longer infectious as far as the chickenpox is concerned. If they become secondarily infected the "impetigo" may be contagious, but that is a separate issue.

As the complications are more often encountered among adults and neonates, who acquire it from affected mothers, it would be more logical to encourage every child to get the disease. For the immunosuppressed and those on long term steroid treatment, who pose special problems, the best protection may be found in the new vaccine. Up to a decade ago the main "complication" was not the illness but the fear that perhaps the patient had smallpox: that risk is, we hope, past.

Dr Kavalier thus poses a reasonable question. Why should we continue to exclude from school children who have chickenpox? The last edition of *Control of Infectious Diseases*, a book which is published by the Department of Health and Social Security in 1977, I understand that a revision is in preparation, and I hope that the new authors will relax a rule that is now unnecessary and even perverse.—Grove Health Centre, London W12 8EJ.

Dr Nellie Adams—It is difficult to date the origin of isolating the individual with chickenpox from the rest of the community, a practice which has found its way into our textbooks. It is reasonable to assume that the Victorian physicians considered it necessary to isolate the person with chickenpox to protect other children from this highly contagious disease—the high prevalence of malnutrition and general poor health probably exaggerated the morbidity and mortality of children who caught the disease.

Serious complications from chickenpox are rare in children today. The mild encephalitis that occurs in 1 1000 cases has a better prognosis than measles encephalitis. On the other hand, protecting other children from contracting the disease is only storing up potential problems for adulthood. Not only is the disease more severe and the complications of varicella pneumonia more common in the susceptible adult, but also maternal infection during the first three months of pregnancy is associated with congenital varicella syndrome. The rate of neonatal varicella from maternal infection during the three to four days before delivery and in the neonatal period is 20%, with a high mortality of 35%.

I entirely agree with Dr Kavalier that it is the immune compromised patient who deserves to be protected from chickenpox. It is doubtful whether isolating the child with chickenpox effectively protects other children anyway. Keeping only children who are ill with chickenpox away from school is reasonable.—North Wembley, Middlesex HA0 3SX.

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