# GENERAL PRACTITIONERS' RETIREMENT PLANS AND FACTORS INFLUENCING THEM

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## INTRODUCTION

Whether general practitioners retire early, late, or at what is regarded as the conventional time (65) is likely to have substantial implications for manpower planning - in the UK for example in connection with the demand for and establishment of vocational training schemes. With the exception of a survey conducted in inner London (London Health Planning Consortium, 1981), little has been established about GPs´ plans and the factors influencing these. Indeed, the only relevant study of retirement intentions and related attitudes known to the authors was restricted to anaesthetists in Yorkshire (Smith, 1980).

Older medical practitioners are frequently less successful on measures of clinical performance (Burg, 1979) and there are suggestions that they are less likely to involve themselves in continuing medical education activities (Stoane, Harden and Dunn, 1982). Coupled with the fact that 29% of practising GP´s in Great Britain aged 65 and over are in single-handed practice, as compared with 14% overall (DHSS Statistics and Research Division, personal communication) and thus not receiving daily "peer review", this may give rise to a concern about the clinical performance of older practitioners. It would therefore be particularly useful to know about the retirement plans of these doctors and factors influencing these.

A study was thus undertaken which investigated the factors perceived by GP´s approaching conventional retirement age (or who had passed this) as pressing them towards earlier or later retirement; it examined the retirement intentions of a national sample of such GP´s.

## METHOD

Exploratory personal interviews were conducted by a medically-qualified interviewer (M.R.) with a random sample of 25 GP´s aged 55 and over from two NHS regions, one primarily urban, one principally rural (NE Thames, East Anglia). On the basis of these interviews, a structured interview schedule was constructed: this covered retirement intentions and factors influencing these.

To conduct personal interviews with a national sample on a face-to-face basis would obviously be prohibitively expensive, yet postal questionnaires did not seem the appropriate method of data collection for such a personal subject, and a poor response rate could be anticipated. A compromise method might be the telephone interview. Whilst the telephone interview is probably not an appropriate method for the initial identification of issues nor for their in-depth discussion, it has been found reliable in surveying the views and attitudes of a professional group (Pendleton and Wakeford, submitted for publication). This study showed how comparable results can be obtained from either a relatively small number of telephone interviews of randomly-selected respondents or a larger scale postal questionnaire.

We decided therefore to undertake our primary data-collection by means of telephone interviews, supplementing these with personal interviews with an additional sample of older doctors, aged 65+.

The samples of doctors were drawn from the Medical Directory, making the assumption that the age of doctors at qualification is 23. (The Directory gives only a doctor's date of qualification, not his/her age. We thus excluded from the study any potential subjects who qualified substantially later in life than this.) Pages of the Directory were drawn at random, and the first evident general practitioner based in Great Britain, 55 years of age or older, was selected for the study. Any subjects found at interview either not to be in General Practice or to be younger than 55 were replaced.

250 names were drawn in this way for the national telephone interview study. For the personal interviews of older doctors, a further 25 names of doctors aged 65+ practising in the two local NHS regions were selected at random from lists of such doctors provided by the Medical Mailing Service.

The content of the interview covered:

- type of practice, premises and list and partnership size
- professional activities (other than providing primary care for NHS list)
- CME activities
- retirement plans now
- factors influencing earlier or later retirement
- attitudes toward a possible "compulsory retirement age"
- outside interests

## RESULTS

197 of the 250 doctors in the telephone interview sample were traced and contacted, and agreed to be interviewed. This involved a total of 786 telephone calls and represents a 79% response rate. All respondents were over 55 years of age: their mean age was 61.4. 43% were aged 55-60, 39% were 60-65, and the remaining 18% were over 65.

### Type of Practice

Rather less than a third of the respondents were in city practices, a similar number in "small or large" towns, the same in "semi-rural" practices, and 8% in rural ones. Two thirds were in practices of 5,000 - 10,000 patients, and 18% from smaller practices and 16% from larger ones. Only 6% of respondents were in a single handed practice.

With the exception of short periods out for national service, almost all the GP´s had been in lengthy continuous practice in the same location - average length of service in present practice = 28 years, average continuous length of service = 32 years. 96% were unrestricted partners.

### Professional Activities

Table 1 shows the respondents´ professional activities other than providing care for their NHS patients. (More than one response allowed.)

**Table 1. "Does your work include any activities other than providing primary care for your NHS list?"**

Industrial medicine = 45%
Other = 28%
Private practice = 17%
Nursing home, etc. = 13%
Police surgeon = 13%
Medical training = 10%
Hospital sessions = 7%
Research = 0%
None = 38%

Well over a third of the doctors thus had no professional activities beyond their regular NHS work. (The category "Other" includes activities such as doing medical examinations for insurance companies and the DHSS, and providing medical services for sports teams, boarding schools and schools/homes for handicapped children/adults.)

Table 2 shows where the respondents reportedly obtain their continuing medical education (CME). Journals and the postgraduate centres are the most frequently mentioned, with practice meetings being little favoured.

**Table 2: "What do you rely on for continuing education?"**

Journals = 98%
Intra-practice meetings = 1%
Meetings with other practices = 1%
Meetings, courses at PGCs = 81%
Local medical societies = 4%
Hospital consultants = 16%
Other = 11%

Journals mentioned include the BMJ (93%), the Practitioner (80%), Update (30%), Lancet (25%), RCGP Journal (5%), video and cassettes (5%), and free

journals such as GP and Pulse (41%).

## Retirement Plans

The GPs were asked at what age they intended to retire and ideally at what age they would choose to retire. Only 55% of the sample could respond unequivocably to the first question: the average "intended" retirement age reported was 65.1 years. 57% of the sample responded to the second question. The average "ideal" retirement age reported was 64.9 years - essentially the same.

Given the opportunity, 46% of the GPs would like to take 24 hour retirements and then continue with reduced work loads (Table 3). 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 in single GP practices, 40% indicated that they would not opt for or could not take some sort of gradated retirement. In most cases (90%), retirement intentions were not written into respondents´ partnership agreements.

**Table 3: "Will you opt for some sort of gradual retirement?"**

| | |
|---|---|
| 24 hour retirement | = 46% |
| Modified partnership agreement | = 8% |
| No nights/on-call/ house call | = 2% |
| No | = 40% |
| No answer | = 4% |

Most GPs in the sample (78%) will be entitled to full pension on retirement. Most (78% again) have purchased additional years so as to

reach "full pension" status.

## Factors Influencing Timing of Retirement

The GPs were asked to identify factors that might influence them to retire earlier rather than later, and, conversely, the factors that might influence them to retire later rather than earlier. To each of these items, about 34% of the sample could offer no reasons (not the same 34% for each item). See Tables 4 and 5 for the results.

"Job satisfaction" was identified as the dominant influencing factor. Lack of job satisfaction would lead to early retirement (42%) and continued job satisfaction would lead to later retirement (55%). Poor health was the second factor (19%) identified as contributing to early retirement; being needed by patients (15%) and financial reasons (13%) were given as the next factors contributing to the delay of retirement. Several doctors expressed the wish to "die in harness". Many of those expressing extreme reluctance to leave the profession listed no interests but medicine when asked about interests and activities outside work and medicine.

Table 4: "What do you see as being the major factors which would tend to influence you to retire earlier rather than later?"

Lack of job satisfaction = 42%
Poor health = 19%
Not keeping abreast/ not providing good service = 11%
To pursue other interests = 8%
Other = 4%
Family = 2%
Changes in the law affecting pensions/ retirement = 1%

No answer = 34%

Table 5: "What do you see as being the major factors which might tend to influence you to retire later rather than earlier?"

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

No answer = 34%

The doctors were asked whether they were looking forward to retirement. 9% could not say; 42% were looking forward to it, but almost half - 49% - were not. Those aged 60-65 were significantly more looking forward to retirement than were those aged 55-60 (or those over 65).

### Views on Retirement Policy

The majority of GPs in the sample held views concerning formal retirement policies consistent with their positions as self-employed professionals. 77% indicated that there should not be a formal retirement policy for

GPs (though the younger groups were less sure then their elder colleagues); 79% wanted no compulsory retirement age; and 80% wanted no further formal controls, safeguards or assessments directed at older practising GPs. In the main, these doctors felt that partners and patients were the best judges of competence.

Generally, those favouring formal safeguards (20%) suggested that they consist of internal (within the profession) voluntary audits, that the results be held confidential, and that there should be no possibility of disciplinary outcomes. 77% of the sample felt that the present system of safeguards is adequate.

## The Older GP´s

In order to explore further the situation of the older GP (65+), a further 25 were selected for personal interview. 16 were ultimately contacted and interviewed (64%). Whilst no additional issues emerged - and indeed the small number involved would not permit statistically valid generalizations - two contrasting vignettes of such older doctors are presented to offer a perhaps more graphic picture of their situations and attitudes. Beyond this, the group will not be discussed further.

**Doctor A: aged 78, in the same three-partner rural practice for 50 years.** Practice provides own cover but uses a locum once a week.

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 you to go on it´s clear you´re fulfilling a useful role."

Retirement intentions: Has none. 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: aged 76, 36 years in same inner-city practice which he joined after emigrating to UK from Eastern Europe. Took 24 hr. retirement at 72.** Three partner practice using deputising service for nights and weekends. Dr. B attends PGC 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".

Views on retirement: "Experience is more valuable than academic knowledge. GP is like the stage - if the public want the actor he carries on. GP´s are like judges - they get better as they accumulate more experience. But each GP 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".

Retirement intentions: No idea when he will retire completely. He will continue 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".

## A CLASSIFICATION OF RETIREMENT INTENTIONS

From the data provided in this interview, respondents can generally be regarded as falling into one of four categories:

A. Those who have "had enough" and want to retire early/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 want never to retire ("never")

The "want out soon" group is frequently characterised by statements concerning a lack of job satisfaction, such as: "I´m getting tired and not

enjoying my work as much as I used to"; "I feel drained and need to recuperate". The "clean break-ers" more frequently mention family and non-job matters, for example: "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 emphasise the value and experience of the older GP, that they know of no other way of life, and - frequently - that patients have asked that they not retire.

Not unexpectedly, there is an association between this classification of retirement intention and age: this is demonstrated in Table 6, which shows the distribution of the 189 doctors whom it was possible to classify.

Table 6: Classification of Retirement Intention, by Age

| Classification of Retirement Intention (see text) | Present Age 55-60 | 61-65 | 66+ | All Respondents |
|---|---|---|---|---|
| Want out soon | 1% | 6% | 0% | 3% |
| Clean break | 46% | 42% | 9% | 38% |
| Gradual | 49% | 42% | 57% | 48% |
| Never | 4% | 10% | 34% | 11% |
| | 100% | 100% | 100% | 100% |
| n = | 81 | 73 | 35 | 189 |

The retirement intentions are reflected by differing attitudes towards the possible introduction of a formal retirement policy - see Table 7.

Table 7: Retirement Intention and Attitude to a Retirement Policy

| Classification of retirement intention | % of group favouring a formal retirement policy |
|---|---|
| Want out soon | 0% |
| Clean break | 49% |
| Gradual | 8% |
| Never | 0% |

## DISCUSSION

For most GP´s, general practice is a lifetime´s career, almost always spent in the same place. For many, their only medical activity consists of providing care for their NHS list; many also devote their whole life to their practice, in every sense, 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 GP´s are often not able to be very specific about their retirement plans - especially to being able to put a planned date on them. This study suggests that nearly half of GP´s can be expected to take 24 hour retirement and continue practising with reduced commitments - very few plan simply to cut out after-hours cover, etc. About half of GP´s will make a clean break of their retirement, a very few (a few percent at most) doing so some years earlier than is conventional. All this points towards a substantial continuation of the present position

whereby 5% of the principals in general practice in Great Britain are over the age of 65 (DHSS Statistics and Research Division, Personal Communication).

Although the need for income and the possibility of poor health were important factors tending to push GP´s to think of retiring later or earlier (respectively), the most important one was job satisfaction or lack of it. 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 as to how accurate these perceptions are and how appropriate the aspirations, which sometimes seem more doctor- than patient-oriented - particularly when it is remembered that nearly half of our respondents reported themselves as not looking forward to retirement. Whether it is in patients´ interests that their GP should "die in harness", especially if single-handed, must be arguable, for example. This slight air of unreality is most evident when the GP´s were asked about the desirability of additional safeguards regarding older GPs´ competence: few were keen on this, and even that fifth that was, wanted the safeguards to have no enforceable effect.

Repeatedly, we were told that GP´s must not be made to retire at a particular point, but they should be able to choose and that they should and would know when the time had come that they were no longer competent. In view of the relatively large number of GP´s planning to work on after 65, it would seem timely to test out this hypothesis. Either by means of

peer-evaluation and/or patient feedback, it should be confirmed whether or not older GP´s are able to evaluate their own broad competence.

This is, we believe, the major implication of this study. We had hoped that it might have been possible to investigate more closely the GP´s CME activities and comment upon these: unfortunately, time was against us in the telephone interview and we had to limit this aspect of the research. Perhaps our other most important finding was that contrary to some popular belief, the number of GP´s planning to take very early retirement is small.

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