

A Psychiatrist Retires: An Oxymoron?

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The author examines the various factors that a psychiatrist may consider in making the decision whether or when to retire. These include one's professional persona, the prevailing professional culture, attachment to patients, practice situation, age, health, family situation, finances, other interests, other professional commitments, adaptability, and more. Personal experience and the limited literature indicate that the prevailing psychiatric professional culture is averse to retirement, but this may vary with changing practice patterns. The decision is a highly individual one that calls for much thought and preparation. This is the first of two articles dealing with retirement. (*Journal of Psychiatric Practice* 2011;17:351-354)

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To the older psychiatrist considering the future of his or her professional life, it may seem as if psychiatrists live in a different world. All around, classmates from college or medical school are retiring, but fellow psychiatrists of the same vintage are laboring on as usual with no apparent end in sight. Colleagues in their seventies and even eighties—most of them—seem almost as healthy and vigorous as they were 20 years ago. Work feels rewarding, the income from practice is nicely augmented by Social Security and mandatory distributions from retirement plans, and one's work is needed in an environment chronically short of psychiatrists. One is attached to the patients and challenged by their psychic processes, and one cares about how they are coping with their difficulties. Being a psychiatrist is very much who you are. It is easy to put retirement on the back burner. The occasional colleague who begins to seem forgetful, makes some errors, may be a little inappropriate at times, and thus becomes a problem for the professional community¹ presents a little cloud of doubt to this state of denial, but it is

easily dismissed. Likewise with one's own occasional memory lapse or minor error on a prescription. Such were among my thoughts as I approached the decision to retire recently at the age of 78.

The foregoing impressionistic statements are largely consistent with the sparse literature that emerged from a search on "psychiatrist" and "retirement." Most informative were surveys of psychiatrists who were Fellows of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The initial survey of psychiatrists aged 55 years or older found that the respondents who were still working were mainly in private practice—as was I—while those who had retired had predominantly been in public psychiatry. It concluded: "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."²

A second, larger survey of the entire membership of the RANZCP residing in the two countries noted that psychiatrists practicing psychotherapy, forensic psychiatry, or general psychiatry, and those in private practice or psychiatric hospitals, were more likely to be older, and they worked shorter hours.³ The younger and less experienced of the respondents believed that "senior psychiatrists have wisdom to offer to junior colleagues."⁴ Additional findings were that "positive attitudes towards personal ageing were significantly associated with old age, males, and good or excellent self-rated health. Negative attitudes were associated with working in universities and anticipated retirement due to poor health."⁵

Another study from Australia noted that "most psychiatrists continue to work until late in life, with only 18 per cent retiring before age 65. The psychiatry workforce aged significantly between 1995 and

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2003 ($p < 0.001$), with men older than women in both years. A reduction in hours worked by psychiatrists was viewed as reflecting both the increasing proportion of females and the older members of the profession reducing their hours in preparation for retirement.”⁶

The 1996 National Survey of Psychiatric Practice conducted with a random sample of members of the American Psychiatric Association noted that “Since 1988–89, the proportion of psychiatrists 39 years or younger has decreased and the proportion of those 55 years old or older has increased.”⁷ The percent of respondents aged 55 or older increased to 39.0% from 31.9% in 1988–89 and 31.5% in 1982. There was a trend toward psychiatrists working fewer hours per week over the same span of time.

The authors of both the American and Australian studies expressed concern about implications for the psychiatric workforce in the face of needs for service. Similar concerns were expressed in a British study of consultant psychiatrists over 50 years of age, the purpose of which was to address retention issues.⁸ In this sample “the mean age at which consultants intended to retire...was 60 years...”—contrary to the trends shown above. Complex reasons for this included “too much bureaucracy, lack of free time and heavy case-loads.” Discussion included particular issues involved in the British health system, and indicated that the early retirees tended to continue working in a different psychiatric capacity. “Mental Health Officer status is an important determinant in the decision to retire early.” Factors “discouraging retirement include enjoyment of work, having a good team and money.”

The statistics are enlightening, but when the individual contemplates retiring, he or she is an *N* of one. For 42 years I was in solo private practice of general psychiatry and psychoanalysis—the last 32 years in a university-affiliated ambulatory health center that includes most medical specialties. There was a high level of mutual respect among us. Many physicians in other specialties retired at an age younger than mine, with a few notable exceptions. My profile was consistent with the still working psychiatrists in the RANZCP studies, including the fact that psychotherapy was a major component of my practice.

As a psychoanalyst I am in a culture that is even more averse to retirement. In a deeply insightful, useful paper that analytically dissects the effects of aging on the practice of psychoanalysis—effects that

may be either favorable or detrimental to the analyst’s psychoanalytic work with patients and to psychotherapy in general—Eissler observed that “In general, analysts are not led by their aging to prefer retirement to professional activity.”⁹ In both my local professional community and on the national scene, this appears to be the case. Some analysts go on seeing patients until they are well into their 80s or until they die.

Is there a right time to stop? There is no “one size fits all.” Efforts to establish age limits on psychoanalysts’ taking new trainees into training analysis have been controversial and inconclusive. Clearly some people age more rapidly or more severely than others, so that age alone does not translate into effects on competence. How can competence be assessed in any meaningful way, beyond gross measurements of memory and mental acuity, when it comes to skills as subtle as those needed in psychotherapy or analysis? Furthermore, those skills are practiced in private situations that are heavily freighted with transference, countertransference, and emotion. Tragic cases show us that serious deficits can occur without insightful awareness even in brilliant, highly esteemed practitioners. We wish that we could know how to get out just before the “big one” or the onset of dementia. Peer assessment arrangements based on in-depth consultation about clinical work can help to circumvent these problems, but they call for courage on the part of the subject and sensitivity on the part of the assessor.

When one takes a person into psychoanalysis or intensive, long-term psychotherapy, one makes a commitment to be there for that person if at all humanly possible, at the requisite frequency of visits, for as long as it takes. For psychoanalysis, that probably entails a commitment of an average of 5 or more years. As one gets well up into the 70s, the chances of serious illness or declining mental function sadly increase. What is our obligation to patients to avoid placing them in the position of dealing with sudden interruption of their treatment or the troubling awareness that their therapist is not functioning well? I have had enough experience helping patients through the adverse effects of such situations to know that it is no kindness to expose people to those risks, no matter how superb a therapist one might be. For the most part, the adverse changes happen gradually, over a continuum, whereas the decision to end one’s practice is an incisive

event at one point in time. It is hard to act definitively rather than drag on with practice as usual. At a minimum, many analysts in my acquaintance decide not to take on new psychoanalytic patients as they get into the late 70s.

An atmosphere of timelessness, suspended above the order of the clock and the calendar, exists in the intensive psychoanalytic therapies, although it is bracketed by the times of starting and stopping the session. This is essential to the free flow of thoughts and emotions that opens up hidden realms of mental life to awareness. Being goal-directed and time-limited only reinforces the defensive structures that ward off discovery and change. Bringing the relational issues into the transference and countertransference takes long experience together. The therapeutic pair can't make it happen; they have to allow it to happen, in its own way. This gives the psychoanalytic therapies their distinctive effectiveness.

However, time does march on, and therapists get older, and sometimes the reality has to be faced. When the analytic therapist retires, there are bound to be some patients who haven't finished their work to the optimal extent, and an appropriate transition to a well suited therapist must be arranged. It is painful, but, if it is well handled, patients manage it, and sometimes the new pair can open fresh vistas. Recognizing and managing one's own countertransference to these patients is important. Other long-standing patients on long-term medication and low frequency psychotherapeutic maintenance will never be free of need for psychiatric help to sustain a decent quality of life and healthy functioning. It is usually hard to part with these old-timers, with whom there is a real bond based on many years of confronting mental life together. I found that there were very few, if any, with whom parting was a relief rather than a moment of sorrow.

In the role of physician, one sometimes has to be the cause of pain. We feel sad when we do it, and sometimes guilty. Retirement is a more difficult case, because we are ultimately putting our own needs first. Much of what I've already written has to do with protecting the welfare of patients, but at bottom we are considering what is best for us and our families. It can't be rationalized as "grist for the mill" as we can do around vacations or a break for family or health needs. It is for keeps, and we don't get to work it through with the patient after the fact, although a lot of work should be done in advance.

What are those needs? We have to assess our health and mental acuity, our energy or fatigue levels, our will to keep up with the rapidly evolving knowledge base of medicine in general and psychiatry in particular. How much does our family need more of us, especially spouses or significant others, or sometimes grown children? What is our financial status—can we do without an earned income and live on savings, retirement accounts, and Social Security? (Do psychiatrists, especially those in private practice who do psychotherapy, work longer because we never got paid as well and have accumulated less wealth? Or do we just love the work and hate to give it up?)

On a less practical level, we know that our span of life is not timeless or infinite. Can we at last accept that humbling reality? Are there other things we want time and freedom to do in the time that remains? Do we have outside interests to give us motivation and enjoyment, even fulfillment, when we don't have to get up and go to the office? Do we want to travel, broaden our reading, do something creative, work for a cause, see more of our friends and extended family, enjoy the arts, and/or be more physically active? (Sitting in a chair eight hours a day, in an office or at home, is definitely not healthy.) This is time for ourselves and our loved ones. One can say that this is selfish, but more likely it would be a manifestation of Kohut's concept of mature narcissism in coming to terms with our limitations with wisdom, humor, and creativity.¹⁰

Finally, there is our professional persona. Can our self-esteem and sense of self-fulfillment sustain not being a practicing doctor anymore? Will we grieve our professional status and the power of the prescription pad? I'll go back to the University Suburban Health Center—as a patient, not as a doctor on the staff: can I handle this? Psychiatrists tend to let themselves down easy. After closing a practice, we can probably still teach, supervise, and consult if we want to. Some will do some locum tenens work or be in a volunteer clinic a day a week. We will always be needed. But, in retirement, it is on our time and terms, and there is much to enjoy. Flexibility to try new things may lead to very satisfying experiences, especially if one is wise or fortunate enough to retire while still in good health. There is far more to life than the profession we love and have done our best to master, and our time is limited.

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In my next column I plan to write about the process of making retirement happen.

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