

How and Why Do We Retire?

Ill omens for younger doctors

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The nature of our departures from our work often tells us much about what kind of problems are being left behind. The individual may escape, but what about the wider community?

The continuing troubles and discontents of junior doctors have evident newsworthiness; not so the equivalent problems in later careers. This is easy to understand: younger doctors have (we hope) a long future career ahead – that future is also *our* future healthcare, so we want them to be there, and in fine fettle. Older doctors will have retired from that picture: we are less concerned.

So, the morale and welfare of older doctors does not arouse the same kind of public interest or apprehension. Yet older doctors have much to tell us about our direction of travel: they have witnessed and practised many kinds of care and treatment, management and colleagueiality, ethos or its lack. Surely, the story and state of our elders' retirement conveys much about the trend in our healthcare culture and, therefore, what we may expect.

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Throughout my long NHS career I have talked with many doctors about their retirement. In previous decades the better ones (and there were many) left their work often in incremental stages – with much grace, gratitude, dignity, charity and affectionate appreciation. Importantly, this was reciprocal: the sentiments would resonate between their *community* of colleagues and staff. 'The demands have often been difficult but our shared human rewards are rich. Thank you everybody' was a common departing coda.

In the last decade such departures have become very rare. Retirement mindsets now are increasingly of wearied stoicism or sourness: either 'Well I've made it to 60, thank goodness. I just hope there's enough of me left to restore the rest of my life', or

'I'm 56 but my pension is now good enough to go early. I just don't enjoy my work as I did. Not only can I not care for people like I used to, but I don't feel cared for when I'm doing the work. Community?! I have become just a cog in The Machine.'

Less common – though previously almost unheard of – is the rapid and dramatic exit: the *coup de grace* of redundancy, decommissioning, CQC closure or contractual expulsion. Such are quotidian traumas in the realms of business, politics and sports management. The fact that doctors are now increasingly liable to such denouements tells us much about our changed healthcare culture.

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So, if our retirement patterns are any kind of litmus test to predict our profession's future, then junior doctors' concerns will extend far beyond current disputes about pay and working hours.

Why do older doctors now become so enervated and disillusioned? What was different in previous decades? We can start to explain by considering this cluster of losses: the loss of time to care and relate to both patients and colleagues; the resulting loss of headspace and heartspace to make for human meaning and relationships; the inevitable loss of fraternal colleagueiality; the loss of the primacy of personal skills, understanding and trust to guide our work's best decisions and conduct.

These are all losses to our *humanity*: the nourishment, stimulus and satisfactions we garner, exchange and recycle so that people can get to know and care about one another.

But how have we lost these things? These may be best understood as consequences of displacement. For our insistence on quantifiable, standardised, executised procedures has increasingly pushed out the innumerable, yet invaluable, aspects of our humanity that cannot be processed in this way. Deprived of its natural habitat our professional humanity first ails, then eventually dies. This is what the fractious unrest of junior doctors, and the caustic fatigue of retiring doctors, is telling us: we have – by overmanagement and excessive proceduralisation – rendered a world of work inimical to healthy and fulfilled lives.

Our NHS healthcare mostly used to function as a matrix with the ethos of a well-functioning *family*: personal bonds of familiarity and trust allowed for flexibility, natural growth and the friendly inclusion of others. But since the rise of the Internal Market, Corporate Managerialism and then the 4Cs – competition, commissioning, commodification and computerisation – we have created a network of *factories*. In these workers do what they are told: there is a cascade of executive instructions flowing from planners, designers, production engineers, production managers, performance managers etc. The workers' conduct and skills are defined, confined, boundaried, contracted and disciplined by executive decree. Autonomous professional judgement, wisdom, intelligence or experience become inadmissible, then obsolete.

This is the managed world, increasingly, that doctors are working in. From family to factory; from being guided by vocation to being controlled by corporation.

Our current retirement patterns tell us we are destroying the human heart of healthcare. That, surely, leads us to very bleak scenarios.

What can we do to avoid such a debacle? We might start by asking this kind of question: 'how do we best understand one another's human needs?', rather than 'how do we control all these other people?'.

Charity begins at home.

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