



Royal College of  
Obstetricians &  
Gynaecologists

# Later Career and Retirement Report

Retaining O&G Doctors in the Workforce for Longer

March 2020





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# Introduction

In order to provide high quality, safe and compassionate care to women, the workforce must have sufficient numbers of experienced, senior staff who are skilled, healthy and committed. Senior obstetricians and gynaecologists are essential to a well-balanced medical workforce, not only in supervisory roles but also in providing direct patient care alongside their colleagues. Some of the work requires 24-hour, seven-day-a-week presence in hospital, and can be demanding.

Studies are revealing a worrying trend towards earlier retirement for UK doctors. Senior doctors who have devoted their lives to caring for patients in the NHS now find themselves making difficult decisions about their continued involvement in service delivery. This means the loss of much needed and valued skills and experience from the workforce at a time of increasing demands on time and resources and for some, higher levels of stress and burnout.

This trend is of great concern to the RCOG, who believe that the wellbeing of the O&G workforce is at the heart of delivering the best care to our patients. Over the past three years we have been working to understand the workplace challenges faced by our members throughout their careers, so that we can better advocate for the needs of the profession to key stakeholders and decision makers, to mitigate this worrying trend and to support our doctors to deliver the very best for both patients and colleagues.

As part of this work, in 2019 we established a Later Career & Retirement Task and Finish Group to look more closely at the pressures faced by senior doctors and the factors influencing their retirement plans. The group conducted a survey of members aged 35 years and above to gather information on actual and planned retirement. Respondents included advanced trainees, consultants and SAS/locally employed doctors, at a range of career stages including those already retired.

The survey explored people's reasons for retirement, whether this was earlier than planned and what, if anything, might be done to retain them for longer. The reasons for retirement included a lack of flexibility in job plans and on-call, increased pension taxation, not feeling valued, increasing workplace bureaucracy and poor team cultures as well as experiencing concerns that they will not be able to maintain the best possible personal health and wellbeing.

This report provides a summary of the factors influencing retirement plans; what can be done to support doctors who want to remain in the NHS workforce for longer and how to make the later career stage as attractive as possible to all.

We would like to thank the Later Career & Retirement Task and Finish Group for their dedication and commitment to this important work: Felicity Ashworth (Chair), Alison Wright, James Drife, Vanessa Mackay, Laura Hipple, Eman Toeima, Sarah Vause, Rhona Hughes, Simran Bansal, Emma Crookes and Victoria Bytel.



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# Key recommendations

## Key recommendations

The following are expanded upon in the Recommendations chapter towards the end of this report.

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- ✓ Improve the flexibility of job plans during a doctor's career
- ✓ Reduce or stop on call after age of 55-60 years, where desired
- ✓ Recognise and celebrate the skills of senior colleagues through teaching and mentorship of newer colleagues, allowing a change of focus every 10 years
- ✓ Lobby government to reform pension taxation and enable doctors to support their NHS Trusts in providing additional theatre sessions and clinics
- ✓ Improve workplace culture by role modelling civility and respect amongst peers
- ✓ Reduce the administration surrounding revalidation
- ✓ Recognise the time needed in job plans to use electronic administrative systems and ensure they are effective and efficient

A woman with dark hair pulled back, wearing a patterned top and a name tag, is looking down at a document in her hands. She is surrounded by other people in a blurred background, suggesting a conference or meeting setting. The entire image is overlaid with a semi-transparent blue filter.

# Working patterns and retirement



## I. General UK population

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Average age of retirement in the UK is **65.1** years for men and **63.9** years for women<sup>1</sup>. The average retirement age of UK doctors contrasts with trends in the general population.

## 2. Across medicine

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**59.6** Average actual retirement age<sup>7</sup>



**58.9**  
For women



**59.9**  
For men

**142%**

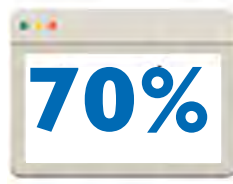
increase in the number of hospital doctors claiming their NHS pension on voluntary early retirement grounds (164 in 2008 to 397 in 2018)<sup>3</sup>

**40%**

of doctors will have to stop taking part in initiatives to reduce NHS Trust waiting lists due to an adverse effect on their pension<sup>4</sup>

**43%**

of doctors who have already retired cite “pressure of work” as a reason for retirement<sup>5</sup>



of doctors are frustrated by the amount of non-clinical work such as administration<sup>2</sup>

Main factors influencing retirement<sup>6</sup>

**85%**

Health and wellbeing

**66%**

Workload

**61%**

Burnout

### 3. O&G

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■ Consultants   ■ Trainees   ■ SAS/Locally employed doctors (LED)



A full time NHS contract for consultants and SAS is comprised of 10 programmed activities (PAs) per week. However, due to service demands, many O&G doctors are working more than this<sup>8</sup>.

**41.7%** SAS/LEDs   **56.02%** Consultant

**<50%** Just under half of trainees and a third of consultants and SAS/LEDs suffer from burnout<sup>9</sup>

In 2019 the RCOG conducted a retirement planning survey of members aged 35 years and above. The survey gathered information on working patterns as well as actual and planned retirement. Respondents included advanced trainees, consultants and SAS/locally employed doctors (LEDs). The following figures are taken from that survey.

The RCOG would like to thank its membership for participating in the survey and providing essential information to inform conversations with key decision makers.

## 4. SAS/LEDs

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Specialty and Associate Specialist (SAS) and locally employed doctors (LED) provide an invaluable service to O&G departments, with many performing highly specialist roles such as running clinics and theatre lists.

**76%**

of SAS/LEDs do on-call work



**31.76%**

of SAS/LEDs doctors expect to retire before the age of 63

SAS/LEDs are more likely than consultants to be resident when working on call

## 5. Consultants

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**59.64%**

of O&G consultants expect to retire before the age of 63 (20% before the age of 60).

**97%+**

of consultants have an NHS pension

**75%**

of consultants have reduced sessions over the past two years

Main reasons for reducing sessions include:

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Achieving a suitable work/life balance

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Pension taxation

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Maintaining health and wellbeing

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Excessive workload incl. too much on-call

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**Key issues**

## Early retirement of UK doctors

In 2014 a national survey of all UK medical graduates from 1974 and 1977<sup>10</sup> found that the average age at retirement among hospital specialists was 59.6 years, that women were retiring earlier than men (men 59.9, women 58.9) and that there was substantial variation by specialty.

The average retirement age of UK doctors contrasts with trends in the general population. Figures from the Department for Work and Pensions in 2018 show that the average age of exit from the labour force for men is now 65.1 years, a rise of two years since 1998. But for women, the average age of retirement has jumped by 3.3 years since 1998 alone, to reach 63.9 years. In recent years the BMJ has repeatedly reported that official bodies, including the BMA, are worried about an impending medical workforce crisis compounded by early retirement.

The commonest reasons<sup>11</sup> given amongst doctors for taking early retirement were pressure of work and reduced job satisfaction with 43% of the doctors who had already retired citing “pressure of work”, Obstetricians and gynaecologists were among those most likely to cite “out of hours work” as a reason for retiring.<sup>12</sup>

## Flexible working

In 2017 the Academy of Medical Royal Colleges (AoMRC)<sup>13</sup> organised a survey with input from all colleges and faculties. It found that 52% of respondents were planning to retire between the ages of 56 and 60, and that 70% were frustrated by the amount of non-clinical, non-patient facing work such as administration. First among the report’s recommendations was that policy-makers should “urgently explore ways to offer older doctors greater opportunities for flexible working”.

A survey by the Royal College of Physicians (RCP) of London in 2017 found that 69% of consultants aged 55-60 would like to retire and return to work on a Less Than Full Time (LTFT) basis. In 2019 the RCP issued a report, *Later careers: stemming the drain of skills and expertise from the profession*. The first of its recommendations was: “Urgently explore ways to offer older doctors greater opportunities for flexible working”.

The Retirement Planning survey carried out by the RCOG in 2019 echoes the findings of these reports.

# Burnout

All the above UK-based reports indicated that burnout is a factor in early retirement. The term “burnout” first appeared in the USA<sup>14</sup>. Defined as “a syndrome of emotional exhaustion, cynicism (depersonalisation) and reduced feelings of personal accomplishment in relation to work”, it has been related to decreased productivity<sup>15</sup>.

A 2019 study into the prevalence of burnout amongst UK obstetricians and gynaecologists, conducted by Imperial College London, and supported by the RCOG, found that just under half of trainees and a third of consultants and SAS doctors suffer from burnout. The study found that burnout was associated with increasingly defensive medical practice, a negative impact on physical and mental wellbeing “and is strongly associated with depression, anxiety and suicidal thoughts”. This has clear implications for the retention of doctors as well as on the efficiency and sustainability of the O&G workforce<sup>16</sup>.

A recent editorial in *Obstetrics & Gynecology*<sup>17</sup> noted that O&G “hovers near the top of any list of burnout among medical specialties”. It agreed that doctors’ resilience may be enhanced by programmes teaching individual skills<sup>18</sup> but also called for a priorities check by institutions: “We must not mistake the call to cultivate resilience as a sign that individual physicians alone can stem the rising tide of burnout”.

Similar problems are occurring in many developed countries. A systematic review of 65 studies (33 from the USA) found doctors’ main reasons for retiring were excessive workload and poor health<sup>19</sup>. In America and Europe, doctors in front-line specialties are most at risk of burnout<sup>20</sup>. Symptoms affect both sexes equally<sup>21</sup> and are more common among doctors than nurses<sup>22</sup>.

Healthcare organisations in the USA have addressed these problems by making new appointments at Director level, with good results<sup>23</sup>. Guidance on late-career transition has been published in Canada<sup>24</sup> and Australia<sup>25</sup>, and the Royal Australian College of Surgeons has modified its CPD regulations with the help of its Senior Surgeons Group<sup>26</sup>.

In some countries like the USA and Canada, many doctors work beyond the age of 70 for financial reasons, and in some specialties, particularly surgery and anaesthetics, doctors are concerned that ageing may affect their technical ability. An international review, however, found considerable individual variation and concluded that assessment of competence should focus on functional ability rather than chronological age<sup>27</sup>.

O&G is a rewarding career but it is also a challenging one. This is well known and more needs to be done to move beyond traditional cultures of endurance and stoicism, which is having a very real and adverse

effect on many doctors. There is a specific role here for the NHS and institutions, for them to look at the cultures and processes within their own departments and to honestly ask if they are doing enough to support their workforce.

## Pensions and taxes

Pensions also feature prominently in the decision to retire early for many doctors. Legislation changes include inclusion of all taxable income, and tapering of the annual allowance. The annual allowance is a threshold which restricts the amount of pension growth a person is allowed each year before tax charges apply. This means huge tax bills for many consultants, which increase the more they work.

Senior doctors who have devoted their lives to caring for patients in the NHS now find themselves being forced to reduce their work commitments, often against their wishes, by pension taxation legislation that imposes large annual tax bills upon them. A recent BMA survey<sup>28</sup> described how 40% will have to stop taking part in initiatives to reduce waiting lists due to an adverse effect on their pension. In many cases, it means doctors are effectively paying to go to work.

The RCOG believes that the best way to resolve this is to reform pension taxation. This reform should include the removal of the tapered annual allowance. The NHS should also introduce a scheme that can be readily understood by its employees. The

The consequences of not doing so not only affects the retention of doctors but can lead to avoidable and often tragic outcomes.

way the current scheme works, and particularly its interaction with the 1998/2008 final salary schemes, is extremely complicated and only fully understood by a small minority of doctors and advisers.

It is important to balance this long-term aim with short-term solutions. Unless immediate steps are taken to mitigate the worst effects of existing pension rules, doctors will continue to be financially penalised for taking on extra work. The NHS needs to find a way to enable, not penalise doctors in supporting their NHS Trusts to provide additional theatre sessions and clinics, in order to reduce waiting lists and improve patient care.

The RCOG worked with a pensions and tax expert to come up with ideas to address the pension tax issues in the short to medium term and has shared these with NHS England in the first instance for consideration.

# Full recommendations





The aim of these recommendations is to support doctors who want to remain in the NHS workforce until their mid to late 60s, and make this option more attractive to doctors who are considering when to retire. Changes need to be effected at three levels: individual, departmental (which involves the Clinical Director and employer) and national, which requires action by NHS policy makers and the RCOG. The recommendations apply to doctors across all O&G roles.

## I. National (Government/NHS/RCOG)

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### Government

- Reform pension allowance issues. This reform should include the removal of the tapered annual allowance

### NHS

- Ensure that flexible working patterns/portfolio careers are available to all staff who wish to choose them (NHS 2019).
- Promote the option of career breaks (NHS employer's handbook).
- Place an onus on Trusts to value staff wellbeing by demonstrating the actions they're taking to support staff.
- Appoint "flexible working" champions in every Trust, not only for trainees but also to promote less than full time (LTFT) work for all staff who wish to adopt this pattern.



## RCOG

- Adapt the job plan approval process to incorporate LTFT templates, include examples of what is working well in some Trusts
- Create a page on the RCOG website for Clinical Directors and members covering the options for doctors nearing retirement, such as reducing sessions, reducing/stopping on call, and retire and return options
- Establish a support network for those working LTFT
- Work closely with the GMC and other Royal Colleges to review the appraisal process for older doctors to make it more relevant and straightforward. For example, irrelevant mandatory learning should be reduced (RCP recommendation 2019). It remains important that those practising clinically must be able to demonstrate their competence

## 2. Departmental (Clinical Director/employing NHS Trust)

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### Job planning

At every annual job planning meeting a discussion should take place about the development and future evolution of an individual's job plan. This could include the acquisition of new interests (e.g. new skills, management, education, mentorship) which are required by the department and fit with those of other staff.

### Long term planning for the department

A long-term model for the department should be developed, with the help of HR, to evolve all job plans over time to enable senior doctors to reduce or stop out of hours work whilst maintaining the required service and being fair to all members of the department which may require compromise.

The following seeks to demonstrate an individual's career progression and why the department needs to have a long term plan to allow evolution of each doctor's career over time whilst maintaining the service



### New consultants

- ✓ Learning roles
- ✓ Building confidence
- ✓ Developing leadership skills
- ✓ Greater share of resident on call



### Mid-career consultant

- ✓ Consolidating clinical skills
- ✓ Leading change
- ✓ Stop resident on call



### Senior consultant

- ✓ Provide stability
- ✓ Transfer knowledge
- ✓ Minimal on call

## Flexibility

- Flexibility with job planning is needed, including the option of working less than fulltime (LTFT). There should be the opportunity for job shares or LTFT working at the time of appointment or when an existing doctor wishes to reduce sessions and could job share with a newly appointed or existing consultant. Although job sharing can be expensive for the Trust it is cheaper than recruiting agency locums. Another form of job sharing would be for one person to work full-time for six months and then swap with their 'job share'. This would enable doctors to pursue other interests (e.g. work abroad or undertake research) without leaving the department.
- Promote and facilitate career breaks. Develop a department policy to share the opportunities fairly between staff and have arrangements in place to backfill the work. A career break might be unpaid or 'earned' by doing a little extra work each week to go towards time off (RCP recommendation 2019).
- Increase flexibility of working, both by location and time. This could be by facilitating administration and supporting professional activities from home and would require secure IT systems to access the Trust's patient notes and test results.



## On call

- Departments should develop systems to allow senior staff (around age 55yrs onwards) to stop night work if they wish, whilst contributing to an equal share of other less popular work such as working on call at weekends or twilight shifts.
- In some units, the younger doctors may need to work on the resident on call rota for a number of years but then move on to non-resident on call and later take up daytime/ evening out-of-hours sessions only, or stop all out of hours work.

## Department culture

- It is essential to improve the culture within departments and Trusts so that doctors feel happy at work and do not feel undermined. Better communication within the consultant body should be developed. There must be fairness, transparency, options for change in job plans within a department, and team discussions about taking annual leave. Social activities are important for staff communication and morale.
- Some staff develop long term medical conditions. Departments and Trusts must recognise this, ensure good occupational health and make necessary alterations in the job plan.

## Administration

- Reduce the administrative burdens on senior doctors – or allocate more time for these. Electronic systems have created more work and this must be recognised. Some tasks can be shifted to administrative staff, and there should be improved team working and efficient systems for routine tasks such as checking results.

### 3. Individual

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- ✓ Acknowledge the clinical needs of your patient population and the needs of your colleagues but don't be afraid to ask for change
- ✓ If you wish to reduce your work, make a plan and discuss it with your colleagues and at your annual job planning meeting
- ✓ Offer to do more of the 'unattractive' sessions in return for reducing night time working
- ✓ Offer to mentor newly appointed colleagues e.g. for major gynaecological surgery. They will appreciate the support and opportunity to operate, it will also ensure succession planning
- ✓ Get advice on working LTFT from your Trust champion (if available - see above)
- ✓ Consider reducing sessions within the department's overall plan or job sharing
- ✓ You might consider applying for a new post at a Trust with less workload or an advertised special interest. Smaller units need staff with plenty of general experience
- ✓ Evolve your work interests over time towards less acute work and more support and mentoring
- ✓ Employ a financial advisor who has knowledge of medical pension arrangements





# Conclusion and next steps

## Conclusion and next steps

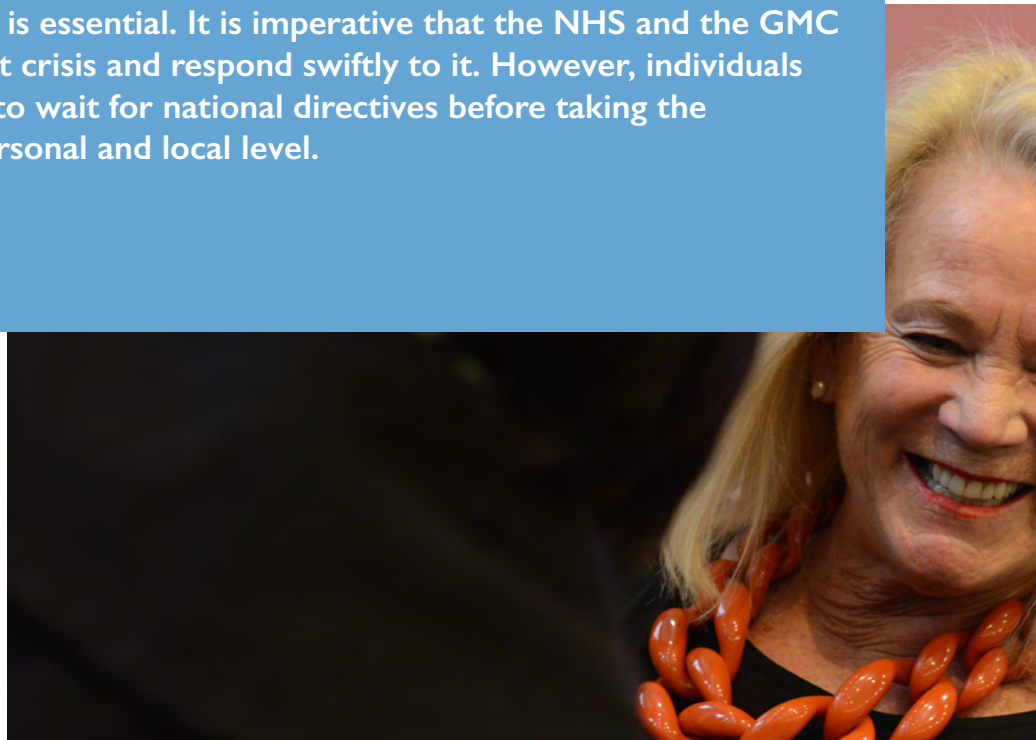
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The urgency of these recommendations cannot be overstated. The RCOG should lead the way by discussing and implementing those relevant to the College itself.

Individuals are invited to consider our suggestions relating to their own plans and working patterns, and discuss our recommendations with their Clinical Directors.

Clinical Directors are urged to take the initiative in helping their Trust to lead the way in creating a culture that values the contribution of senior staff. Local rates of early retirement should be monitored and published.

Change at national level is essential. It is imperative that the NHS and the GMC acknowledge the current crisis and respond swiftly to it. However, individuals and Trusts do not need to wait for national directives before taking the necessary action at a personal and local level.



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