Life & Times

Beyond the clinical coalface:

utilising the transferable skills and expertise of former GPs within the NHS

'One cannot live the afternoon of one's life according to the programme of one's morning, for what was great in the morning will be of little importance in the evening and what in the morning was true will at evening have become a lie.'
Carl Jung, *The Structure and Dynamics of the Psyche,* 1960.

The identity of so many GPs is tied up with their role as a clinician — they have spent their early years working towards achieving this goal and their middle years learning, consolidating, and reaching the expert stage of their career. Along the way they will have learnt many other skills — they may also be employers, managers, mentors, negotiators, and educators.

'Normal' retirement for the current cohort of retiring GPs, who are part of the 1995 pension scheme, is 60 years. At an early stage many will have been planning for their retirement at that age, encouraged by their financial advisors.

For many of them, 'normal' general practice was working 8–10 clinical sessions a week plus being on call. In 1997, 87% of GPs were contracted to work full-time.[1] Having done this for 30 years or more, many are ready to leave frontline patient care. Another factor is that *'The job moves on, and so do we'* as stated by Ed Warren in his *BJGP Life*/*Life & Times* article: *Retirement and managing the* 'peridoctorpause.'[2] This does not mean that some GPs may not want to contribute to primary care in non-clinical ways. Life expectancy has increased since they first qualified, and when they reach the age of 60 years they may well find they want to pursue other roles.

MOVING ALONG A DIFFERENT CAREER PATHWAY

Former GPs may want to move along a different career pathway not because they are 'burnt out' but because they have reached the pinnacle of their GP career and want a new focus, new challenges, and a different pace of life.

However, the instant they retire from clinical work they encounter barriers. The system of appraisal and revalidation has ensured that to maintain one's licence one has to continue to work clinically. Many non-clinical roles still require a 'licence to practice' — the reason why many GPs continue to work clinically for a token one session a week. This is fine for those who wish to do so but the system currently shuts out those who feel strongly that this does not fit in with their idea of being a family doctor. The coalface GPs who have spent many years working intensely are the most hard done by when they retire clinically as they have no established links with medical schools, the Royal College of General Practitioners (RCGP), or NHS organisations to continue when they drop their clinical role.

THE WORD 'RETIREMENT' IS ANATHEMA TO MOST BABY BOOMERS

GPs who stop clinical work are automatically referred to as 'retired'. In fact, a GP's identity is often so tied up with working in a practice that they automatically refer to themselves as 'retired' even when they continue doing locum or non-clinical work. Indeed, doctors in later career who reduce their clinical sessions are described as 'semi-retired', whereas a First 5 or mid-career GP would be referred to as a 'portfolio GP'. The word 'retirement' itself has been challenged: *'The word retirement is anathema to most baby boomers, whose high-powered careers have been core to their whole identity. We need to harness and leverage the skills and energy of doctors at the expert/mastery stage of their careers.'*[3]

OPPORTUNITIES WITH COVID-19 BREAKING DOWN BARRIERS

The response of retired GPs to the COVID-19 pandemic and their return to clinical, educational, and peer-support work has demonstrated that there is a vast well of experience that can be utilised post-COVID-19. Initiatives are needed now to specifically utilise the many transferable skills of GP returners both clinically and in non-clinical roles within PCTs and organisations. Job advertisements should only include an automatic licence to practice requirement for those doing hands-on clinical care. Relevant job experience would be a core requirement for such posts. Here are just a few suggestions for starters:

- Credibility for non-clinical roles should be provided by many years of clinical experience, buttressed by professionalism, ability to learn new skills, and competence in keeping up to date with whatever role is pursued.
- What if PCNs were given the flexibility to use the Additional Roles Reimbursement Scheme to employ senior ex-GPs? Practices could put forward work they haven't been able to prioritise but which needs doing.
- Are any medical schools having difficulty covering any areas of undergraduate development?
- Could the Mentorship Programme now available to GP Fellows be built upon using the ex-GP workforce so that all GPs could have support?
- What could be the role for ex-GPs in training nursing home and reception staff? Could they help bridge the secondary/primary care culture gap?
- What if research practices and academic departments of general practice could use this skilled resource?

Is anyone out there listening?

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