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Reasons why some UK medical graduates who initially choose psychiatry do not pursue it as a long-term career

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ABSTRACT

Background. Some doctors who initially choose psychiatry do not pursue it as a long-term career. The study seeks to identify reasons for leaving psychiatry.

Method. Postal questionnaire survey of UK medical graduates of 1988, 1993, 1996 and 1999 identified as having left psychiatry; for comparison, doctors who left general practice or trauma and orthopaedics.

Results. Response rate was 74% (572/778); 488 respondents satisfied study criteria (59 psychiatry, 318 general practice, 111 trauma and orthopaedics). The speciality's poor public image, perceived lack of respect from medical peers, perceived threat of violence from patients, under-resourcing and low morale were problems for psychiatry leavers. Job stress, self-assessed unsuitability, and concerns about the lack of evidence-based treatments also influenced decisions to leave psychiatry.

Conclusions. Early exposure to psychiatry may help trainees assess their suitability. Negative perceptions of workforce issues (e.g. low morale) and of clinical issues (e.g. perceived lack of ability to improve prognosis) need addressing to increase retention.

INTRODUCTION

The percentage of UK graduates who express an early choice for psychiatry as a long-term career has remained stable during the past 30 years (Goldacre *et al.* 2005). However, the numbers entering the speciality are below those required to fill new posts and replace those ceasing to practise (Brockington & Mumford, 2002). Furthermore, of those who expressed an early career choice for the speciality, 20–30% were not working in it 10 years after graduation (Goldacre *et al.* 2005). The March 2005 Department of Health Vacancies Survey for England (Department of Health, 2005) shows that 7·7% of consultant posts in psychiatry were vacant, compared with a vacancy rate for consultant posts in all specialities of 3·3%. Thus, recruitment and retention are problems facing psychiatry in the UK (Cox, 2000; Brockington & Mumford, 2002; Storer, 2002; Department of Health, 2005). This is also the case in the USA (Feifel *et al.* 1999; Tamaskar & McGinnis, 2002) and Australia (Malhi *et al.* 2003).

Research on recruitment into psychiatry in the UK, USA and Australia has identified negative views that medical students hold: psychiatry is seen as understaffed, under-resourced, excessively bureaucratic, methodologically unscientific, lacking an adequate evidence-base, stressful, and beset with heavy workloads and high public expectations (Sierles & Taylor,

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1995; Wilson *et al.* 2000; Brockington & Mumford, 2002; Clarke-Smith & Tranter, 2002; Rajagopal *et al.* 2004). However, retention issues, including the views held by UK junior doctors about psychiatry, and their reasons for not pursuing it as a choice of long-term career, have not been clearly identified (Storer, 2002).

The UK Medical Careers Research Group (UKMCRG) has followed the careers of medical students who graduated from all UK medical schools in the years 1974, 1977, 1980, 1983, 1988, 1993, 1996, 1999 and 2000 (Parkhouse *et al.* 1983; Ellin *et al.* 1986; Lambert *et al.* 1996, 2003*a*; Goldacre *et al.* 1999). Towards the end of the first year after graduation we send a postal questionnaire to each medical graduate from each UK medical school. Subsequent surveys of each cohort are conducted at approximately two-yearly intervals. In each survey we ask 'What is your choice of long-term career?' We, therefore, have data that can be used to identify doctors who have changed their career direction. A qualitative study of the reasons given by UK medical graduates of 1996 and 1999 for rejecting initial career choices (Lambert *et al.* 2003*b*) suggested that, for those who rejected psychiatry, a lack of enjoyment of the job content was the most important factor in their decision.

For the present study, we surveyed junior doctors in our cohorts who had expressed an early choice of long-term medical career for psychiatry but subsequently changed their intentions. The doctors identified which reasons, from a presented list, had most affected their decision to change speciality. To determine whether changes in career were influenced by factors specific to psychiatry, we also surveyed doctors who had initially chosen but then rejected general practice (GP) or trauma and orthopaedics (T&O). We hypothesized that the reasons affecting retention in psychiatry would be different from the other two specialities, which would imply specific measures should be considered to address them. We chose GP and T&O for comparison with psychiatry in order to determine whether the reasons given for rejecting psychiatry differed from those given for rejecting a community-based speciality (GP) or a hospital-based speciality (T&O). We aimed to identify the reasons that related specifically to recruitment and retention in psychiatry, and suggest ways of advancing the debate on how to attract recruits to and retain doctors in UK psychiatry. We focused on the graduates of 1988, 1993, 1996 and 1999 to provide information that could be considered to be the most recent and relevant to current recruitment and retention issues.

Ethical approval for the UKMCRG cohort studies was obtained through the Central Office for Research Ethics Committees (COREC), following referral to the Brighton Mid Sussex and East Sussex local research ethics committee.

METHOD

Two criteria were used to select doctors for the study. Doctors were selected if:

(1) in either, or both, of the first and third years after graduation, the doctors had specified psychiatry, GP, or T&O as their first choice of long-term career but, subsequently, by the fourth or fifth year after qualification, had changed their choice; and/or
(2) they had worked in one of these specialities whilst in a training grade but, subsequently, had not completed their training in that speciality.

These criteria identified 798 participants from the four cohorts (99 psychiatry leavers; 549 GP leavers; 150 T&O leavers).

The authors developed a questionnaire to ascertain a doctor's views about either psychiatry, GP, or T&O (as appropriate) and their reasons for not pursuing the speciality as their long-term career. The questionnaire comprised 31 statements covering four sections: general aspects, training, career posts, and clinical and personal aspects (see Table 1). Statements were derived from other research (Wilson *et al.* 2000; Brockington & Mumford, 2002; Storer, 2002), editorials (Cox, 2000) or anecdotal evidence. Doctors were asked to consider each statement and indicate whether they 'agreed', 'disagreed' or had 'no view'. Those who agreed with a statement were asked whether it had affected their decision to change speciality. Each participant was asked to respond to all statements in the sections covering general aspects, training and career posts. Participants who had undertaken postgraduate work in the speciality were also asked to complete the section on clinical

Table 1. *Rating of potential reasons for leaving psychiatry (Psy), general practice (GP) and trauma and orthopaedics (T&O), by doctors who have left each speciality*

Statement	% who agreed with statement			% who agreed with statement and agreed it had affected their decision to change speciality		
	Psy	GP	T&O	Psy	GP	T&O
(A) General						
The speciality …						
Was under-resourced relative to other branches of medicine	39[ab]	13	6	20[ab]	5	5
Clinical priorities were distorted by the need to meet managerial objectives	15[a]	31	19	12	14	13
Individual doctors were blamed for unavoidable adverse patient outcomes	25	26	19	19[b]	10	8
Was staffed by doctors who were difficult to work with	17[a]	7	27	15[a]	4	21
Had a poor public image	53[ab]	23	6	15[ab]	6	2
Was not sufficiently respected by doctors in other specialities	58[b]	46	17	15	9	6
Had low morale among medical staff	42[b]	42	11	36[b]	23	6
(B) Training						
In the speciality, training …						
Lasted too many years	12[a]	2	18	12[a]	2	14
Involved professional exams which seemed too difficult	12[a]	3	11	9[a]	1	9
Involved too much research in order to progress	12[ab]	2	33	7[ab]	<1	23
(C) Career posts						
Thinking about the prospect of becoming a consultant/principal in the speciality, I was concerned that						
The workload would be too onerous	36	41	29	27	30	23
The career prospects would be poor	3[a]	21	10	3[a]	13	9
A post would not be available in the region I wanted	7[b]	11	32	5[b]	6	24
Flexibility would be limited (i.e. the ability to work part-time/take career breaks)	25	15	40	22[a]	11	26
There would be few opportunities to do private work	12[b]	10	1	10	2	1
The risk of litigation would be high	27	27	25	12	13	5
(D) Clinical and personal aspects (only those who have undertaken postgraduate work in the speciality)						
In the speciality …						
My training was not adequately supervised	34	25	23	22	10	10
My training was inflexible with regard to working hours	17[b]	27	39	12	10	17
My training involved on-call work that was too demanding	22	35	32	15	24	18
My training involved routine hours that were too long	10[ab]	25	32	7	16	17
Diagnosis and treatment were not sufficiently evidence-based	42[ab]	22	16	20[ab]	9	6
I found it difficult to relate to the patients	10[ab]	1	1	7[a]	<0·1	1
I found there was little or no improvement in the patients	37[ab]	11	5	29[ab]	6	3
The physical risks of doing my job were too high (e.g. risk of assault by patient)	22[ab]	8	2	15[b]	6	0
I found my work was too stressful	49[b]	35	10	39[b]	31	9
I had a negative experience of a critical incident (e.g. an unexpected death)	15	16	10	5	7	3
I had difficulty balancing my work and private life	34	31	35	29	23	31
I found the work did not suit my temperament	51	48	32	46	45	30
I found it difficult to master the required clinical skills	0	5	5	0	3	5
I found the work boring	12[a]	40	24	12[a]	35	16
I found that the work was not clinical enough	37[b]	30	9	24[b]	27	6

Percentages which are marked [a] and [b] correspond to $p<0{\cdot}05$ for a significant difference in percentage (Fisher's exact test, 2-sided), when compared with the corresponding percentage of those leaving GP and T&O respectively.

Sample sizes on which the percentages are based: for sections A, B and C for psychiatry ($n=59$), for GP ($n=319$), for T&O ($n=111$); for section D psychiatry ($n=41$), for GP ($n=176$), for T&O ($n=88$).

and personal aspects. All participants were invited to give any other important reason why they did not pursue a career in the speciality. Participants who were still in medical practice were asked to give details of their current employment and to indicate their current choice of long-term career.

Statistical comparisons used Fisher's exact test, and differences at a 5% significance level were highlighted.

We performed a power calculation to estimate the sample sizes required to detect a 20% difference between the percentage agreement on a statement (40% agreement compared with

60%, the case requiring the largest sample sizes), assuming the ratio of sample sizes to be 1:2 for psychiatry:T&O, and 1:5 for psychiatry:GP. This showed that the actual sample populations of 59, 319 and 111 for psychiatry, GP and T&O respectively gave ~70% power when comparing psychiatry with GP, and 75% power when comparing psychiatry with T&O, to detect a 20% difference between the specialities at the 5% significance level.

RESULTS

Of 798 doctors who were sent questionnaires, two declined to participate and 18 were untraceable, leaving 778 (96 psychiatry; 535 GP; 147 T&O). The response rate was 73·5% (572/778) and did not differ significantly by speciality (psychiatry 68%, GP 73%, T&O 80%; $\chi^2_2 = 4{\cdot}6$, $p = 0{\cdot}10$). Of the respondents, 18 stated that they had not seriously considered the speciality as a long-term career and 66 advised that they had maintained their early choice of the speciality, after all, as a long-term career, leaving 488 usable replies (59 psychiatry, 318 GP, 111 T&O).

Views about psychiatry

There were two statements with which half or more of all psychiatry leavers agreed (Table 1): 'psychiatry had a poor public image' and 'psychiatry was not sufficiently respected by doctors in other specialities'. In addition, approximately half of those who had undertaken postgraduate work in psychiatry agreed that 'I found my work was too stressful' and 'I found the work did not suit my temperament'.

Between a quarter and a half of all psychiatry leavers agreed that psychiatry 'was under-resourced relative to other branches of medicine', 'individual doctors were blamed for unavoidable adverse patient outcomes', 'psychiatry had low morale among medical staff', 'the workload [as a consultant] would be too onerous', 'the risk of litigation [as a consultant] would be too high' and 'flexibility would be limited'. Among those who had undertaken psychiatry training, between 25% and 50% agreed that 'training was not adequately supervised', 'diagnosis and treatment were not sufficiently evidence-based', 'there was little or no improvement in the patients', 'there was difficulty balancing work and private life' and 'the work was not clinical enough'. Less than a quarter agreed with each of the remaining statements (Table 1).

Comparison with views of those leaving GP or T&O

Statistically significant differences between the percentages of psychiatry leavers and other leavers who agreed with each statement are indicated in Table 1.

Under-resourcing and the public image of the speciality were regarded as significantly greater problems by the psychiatry leavers than those rejecting the other two specialities. Among leavers who had undertaken postgraduate work in the respective specialities, those rejecting psychiatry regarded the difficulty of relating to patients, the lack of improvement in patients, the lack of an evidence base for diagnosis and treatment and the physical risks involved in doing the job as greater problems than did those rejecting the other two specialities.

Long training hours were regarded as less of a problem in psychiatry than in the other two specialities. Compared with psychiatry, T&O scored favourably on respect from other doctors, stress, staff morale, the opportunities to do private work, and the degree of clinical content in the work. GP scored well on the ease of working with other doctors in the speciality, short training with easier professional exams, and a low level of requirement for research experience in order to progress.

Consequences for career choice

Table 1 also shows the percentages who both agreed with each statement *and* agreed that it had affected their decision to change speciality. Among those who rejected psychiatry, having undertaken postgraduate work in the speciality, 'I found my work was too stressful', and 'I found the work did not suit my temperament' had been strongly influential in decisions to change speciality, while the other two statements with which more than half of all psychiatry leavers agreed, 'psychiatry had a poor public image' and 'psychiatry was not sufficiently respected by doctors in other specialities', had only affected the decision of 15% of psychiatry leavers.

Low morale and the onerous workload as a consultant had influenced the decisions of at least a quarter of those rejecting psychiatry, and among those who had undertaken postgraduate work in psychiatry at least a quarter had been influenced by the lack of improvement in the patients and the difficulty of balancing work and private life.

We leave further comparisons with GP and T&O to the reader. In most cases the results are similar when the agreement to each statement is strengthened by asking the respondent to indicate whether each issue had affected their speciality choice. However some differences were more marked: for example, among those who had undertaken postgraduate work in each speciality, the psychiatry leavers were more likely than others to agree that in their speciality diagnosis and treatment lacked a strong evidence base, and that there was an observed lack of improvement in the patients.

Demographic factors

We considered whether demographic factors might affect the analysis. The main item of demographic information available to us was gender. The psychiatry leavers were 54% female (32/59), the GP leavers, 66% female (210/319) and those leaving T&O, 16% female (18/111). The gender distribution of those leaving T&O was significantly different from that of the psychiatry leavers ($\chi^2_1 = 25{\cdot}0$, $p < 0{\cdot}001$); the difference comparing psychiatry and GP was not statistically significant ($\chi^2_1 = 2{\cdot}4$, $p = 0{\cdot}12$). However, the responses of men and women to the attitude statements were similar to one another on all but one of the 31 statements [the exception was that a significantly higher percentage of women than men agreed that 'the speciality was not sufficiently respected by doctors in other specialities' ($p < 0{\cdot}01$, comparing the responses of men and women)]. We conclude that gender was not generally an important confounder in comparing the specialities in respect of the attitude statements.

DISCUSSION

The number of doctors rejecting psychiatry was restricted in size by the nature of the study, because there were only a limited number of respondents in the four cohorts who satisfied the entry criteria. It was also limited by the period in which the study was conducted; there may have been particular difficulties experienced by these specialities at the time of the study that may no longer be relevant. Our method of structured postal questionnaires is only one of several possible methodologies that could be used to explore doctors' reasons for leaving psychiatry. Accordingly, we regard our findings as indicative rather than definitive. They provide pointers for further exploration. Our reasoning for using GP and T&O as comparison groups was as follows: GP shares many aspects with psychiatry such as the nature of patient interaction, and similar issues may emerge in the area of career choice. T&O provides the contrast of a procedure-based hospital speciality.

For psychiatry leavers who had undertaken postgraduate training in the speciality, the statements that signified the views of approximately half the respondents were 'I found the work did not suit my temperament' and 'I found my work was too stressful'. Both suggest a temperamental mismatch between the trainee and the reality of work in the speciality. Two possible reasons are a lack of prior understanding and knowledge of what is entailed in working in the speciality, or a lack of personal self-awareness. To avoid such mismatches we suggest that interested trainees should have the opportunity of more experience in psychiatry before making a commitment to it as a long-term career choice, together with self-assessment tools or personal counselling to help identify whether they are suited to the speciality. In addition, the role of regular supervision in dealing with stress might also be an area that psychiatric trainers could further develop (Pidd, 2003).

The recent development in the UK of 2-year Foundation posts for new medical graduates offers opportunities for psychiatry. However, it cannot be assumed that simply offering short-term posts in psychiatry, typically of 4 months each, to new graduates will necessarily encourage the recruitment of doctors into the speciality. The posts need to offer the right kind of varied and attractive experience. They should include experience of the subspecialities of psychiatry, and of out-patient psychiatry, as well as in-patient psychiatry.

Although psychiatry was perceived to have a poor public image and to be insufficiently

respected by doctors in other specialities, these 'external' factors seemed to have little influence on doctors' decisions to leave psychiatry. 'Internal' factors related to how an individual doctor coped, or envisaged they would cope, with work in the speciality were more important. These included perception of low morale, under-resourcing, onerous workloads and doctors being blamed for unavoidable adverse patient outcomes; experiences of difficulty balancing work and private life, and the physical risks of the job; and views that patients would not improve and that the work was insufficiently evidence-based. The latter two issues are also highlighted by medical students when asked about psychiatry (Feifel *et al.* 1999; Brockington & Mumford, 2002; Malhi *et al.* 2003). This suggests that tackling these views about psychiatry needs to start at medical school and continue in junior doctor training.

Although the factors highlighted by our study do not represent the views held by all those rejecting the speciality, they present important problems for psychiatry as a career speciality in the UK. The challenge to policy-makers and medical educators is to address them.

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DECLARATION OF INTEREST

None.

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