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Table 3. Current mental health facilities in Nepal inside and outside Kathmandu

Psychiatric facilities	Kathmandu	Rest of country	Total
Mental hospitals	1	0	1
Hospitals with out-patient clinic	7	7	14
Hospitals with psychiatric wards	5	5	10
Psychiatric beds	125	75	200
Psychiatrists	25	5	30
Clinical psychologists	5	1	6
Postgraduate training centres	1	1	2

To maintain their morale and motivation, they will have to set up research projects. Alternative routes to healing need to be identified to suit local needs. Recent advances in psychiatry, as reflected by research and practice in the Western world, cannot be applied directly to meet the mental health needs of the non-Western world. George Hsu (2004) suggests that some of us in the low-income countries should make an effort to channel our research into four main areas: rehabilitation of those with chronic mental illness; treatment of major depression by primary care physicians; developing a more culturally acceptable form of psychotherapy; and reducing stigma associated with mental illness. Non-governmental organisations such as the South Asia Forum on Psychiatry and Mental Health and the Nepalese Doctors' association (UK) are anxious to help Nepalese psychiatrists.

Declaration of interest

None.

Acknowledgements

I thank the Nepalese psychiatrists Dr Pramod Shyngwa, Dr Shailendra Adhikary, Dr C. P. Sedain and Dr Ranjan Thapa as well as the physicians Dr Gaurang Mishra and Dr Vijay Kumar Singh, and all the Red Cross staff for their help at the Janakpur Mental Health Camp.

References

GEORGE HSU, L. K. (2004) International psychiatry – an agenda for the way forward. *International Psychiatry*, issue 4, 5–6.

MENDIS, N. (2004) Mental health services in Sri Lanka. *International Psychiatry*, issue 3, 10–12.

NEPAL, M. K., GURUNG, C. K., JHA, A. K., *et al* (1986) First 156 patients of a new psychiatric outpatient department (OPD): socio-demographic profile and diagnostic status. *Journal of Nepal Medical Association*, **24**, 7–19.

REGMI, S. K., POKHREL, A., OJHA, S. P., *et al* (2004) Nepal mental health country profile. *International Review of Psychiatry*, **16**, 142–149.

SHYANGWA, P. M., SINGH, S. & KHANDELWAL, S. K. (2003) Knowledge and attitude about mental illness among nursing staff. *Journal of Nepal Medical Association*, **42**, 27–31.

UPADHYAYA, K. D. & POL, K. (2003) A mental health prevalence survey in two developing towns of western region. *Journal of Nepal Medical Association*, **42**, 328–330.

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Psychiatric Bulletin (2007), **31**, 350–353. doi: 10.1192/pb.bp.106.012419

LEONARD FAGIN

On leaving

Negotiating the process of leaving a post one has occupied in a senior position for many years can be stressful and emotionally draining. Considerable thought has to be given to the process to ensure that patients, colleagues and the organisation are not badly affected, but unfortunately the literature on the subject is practically non-existent. What follows is a personal account of the process I went through and the lessons I learnt after I made a major change in my professional life.

After 26 years working in the same job as a consultant psychiatrist I thought it was time to 'change direction', to leave the relative security of the 'familiar' and embark on other ventures. I refer to it in this way because I could and still cannot envisage myself as a retiree. If anything I felt in my prime; 'too young to retire' as many people have since told me.

Making a decision

Professionally, I was at that stage when my views were sought and respected. I looked forward to supervising the next generation of psychiatric trainees and had some influence in my trust, having been chairman of division, clinical tutor and clinical director. I was proud to have helped establish a model service in my patch, combining integrated community and in-patient facilities in a seamless network, appreciated by users and workers alike. I enjoyed many aspects of the day-to-day clinical job, even if it had become more stressful in that deprived area of London. I am involved in many College activities, I had a research project, articles and a book on the go. So why change?

Having spent years researching burnout in mental health professionals, one would think that I was in a

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reasonable position to identify any early creeping symptoms, such as urges to avoid problems or a tendency to procrastinate when unpleasant aspects of my job inevitably arose. No, I was too obsessive to let things pile up in the in-tray. Sunday evenings and the return from summer holidays would sometimes fill me with heavy-hearted feelings, but once in the thick of things I would be involved in the hustle and bustle of everyday matters and time would fly by. Difficult patients have always been a fascination for me, despite the often impossible challenges they set, and mostly I was able to retain active empathic relationships and kept listening attentively to their plight. I managed to keep a sense of humour even when faced with the most obstreperous of people. I believe I have a knack for getting on with colleagues, even those with difficult entrenched personalities, but fortunately I have been very lucky with the excellent group of professionals with whom I have had the pleasure to work.

So the question about 'retiring' still remained. Part of the answer was that the possibility was there. As a mental health officer, I had worked all the necessary years to apply for retirement at 55. A number of respected colleagues had taken the plunge, and on the whole did not appear to me to be confused or desolate, or missing the everyday maelstrom of crises and responsibilities. The pension arrangements provided by the NHS were adequate, and to some extent generous, compared with others in the labour market anywhere in the world.

Eventually, I made the decision that I would not continue to work in the same capacity after the age of 60. More than anything, I wanted to use my energy in other areas, both in my profession and in other endeavours, especially in the creative arena. I was involved in co-editing a book on in-patient care, which I could see would require quite a bit of my time, and I had other writing projects in the pipeline. I wanted to join an oil painting course, take up piano lessons and continue in our symphonic choir.

What made the case clearer to me was the continuing state of change and further unpalatable anticipated proposals for changes to mental health services. My trust had increasingly insurmountable deficits, and management was under pressure from primary care trusts to balance the books 'or else', even at the expense of the viability of services. Hasty management decisions were being proposed which were actively opposed by clinical staff, particularly in my service, where they threatened to dismantle well-functioning arrangements. Bed numbers would be reduced despite the fact that home treatment teams, assertive outreach teams and other services had not managed to reduce occupancy rates. Community teams were to be merged and relocated, distancing them from local communities. Day centres were being decommissioned. As a result of all these uncertainties, many members of staff were looking for jobs elsewhere. I had faced similar situations in the past, but my appetite to fight against these moves was waning fast.

The trust proposed other sweeping and far-reaching plans. Consultants were asked to re-examine their jobs, with a view to switching to functional arrangements, where some consultants would take over in-patient care and others focus on community work. The small campus service I built over many years was to be dismantled. I felt profoundly unhappy about this because of the threat of fragmentation in the continuity of care, and I did not want to be a part of it. In fact it all seemed to be part of a worrying trend: the dehumanisation of the NHS.

Other modifications were being announced at a national level, some for the good, but radical in extent. The introduction of foundation posts, new career structures for psychiatric trainees, the ongoing consequences of the European Working Time Directive, a new Mental Health Act, new roles for consultant psychiatrists, constant weighty guidelines from the National Institute for Health and Clinical Excellence (NICE), the list was endless.

The arrival of a Silver Clinical Excellence Award certainly was welcome news and buoyed by the recognition (and the financial incentive) I decided to hand in my notice.

Communicating

In some ways the decision was the easy bit. How was I going to communicate this to my patients, my colleagues, and my loyal secretary of over 15 years? How did one navigate the transition from a busy catchment area consultant to a freelance agent? Were there any guidelines? Anybody I could speak to? Even though I did find it helpful to speak to a few friends who had been through the process earlier, I felt quite alone.

I booked myself onto a BMA retirement planning seminar (further details can be found from the BMA website at http://www.bma.org.uk). The emphasis was on making adequate financial arrangements, with a little popular psychology thrown in. Nothing very specific to my needs. As a longstanding psychiatric consultant I had to carefully consider how to negotiate my departure in a way that caused my patients minimum distress, and not leave too much of a mess for my successor to pick up. I also wanted to survive the ordeal relatively unscathed!

My first consideration was for my patients, especially those that I had known for many years. Dealing with enduring and chronic conditions, it was inevitable that I would still have on my list patients that I had inherited from my predecessor, and also new ones who I would have to pass on to my successor. In particular, I recognised that I would have most difficulties with patients with personality disorders because of their transferential relationships with myself. Taking some guidance from psychodynamic practice, I decided that I should give patients 6 months notice in order to have a chance to work through feelings raised by my leaving. How could I do this before the date of my actual departure was clear? I had 6 months to wait before it was financially convenient for me to leave, and had to give 3 months notice to my employers. A compromise was in order. I let patients know that there were substantial changes in our trust, and that I could not be certain that I would remain in post over the next half year but that as soon as the situation

https://doi.org/10.1192/pb.bp.106.012419 Published online by Cambridge University Press

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was clear I would let them know. It was the equivalent of sowing seeds of doubt, but at least it gave us a chance to discuss the 'what if' before I was entirely certain of my situation.

Predictable consequences ensued. The informal grapevine started to work and within a week I was constantly being asked whether I was leaving my job. My secretary in particular, who I had informed earlier of my decision, was hounded with questions. We decided to respond in a standard fashion. 'Yes, there are changes likely to occur within the next 6 months but we are not clear about them at the moment, and we promise we would let people know in time once we were sure.' I am deeply grateful to her for managing this situation with such aplomb and understanding when I was very aware that she was also distressed at the notion of me leaving, as we had worked well and closely for over 15 years.

Working through

A number of patients were getting very nervous. 'You can't leave, Dr Fagin. You have been around so long. You are the backbone of the service. What will happen to us? You are the only one who understands us.'

These demands gave us a chance to review the meaning and significance of our association over the years. It helped to challenge not only their views about their involvement with me but also my assumptions about why they needed to continue to see psychiatric professionals. It was a fruitful, albeit at times painful, learning experience for both my patients and me. Once the shock of the announcement was over (sometimes expressed with understandable resentment and feelings of abandonment, and occasionally with acting-out and a psychiatric crisis), we could focus on the task of defining what they wanted from my successor and from psychiatric services. I had already discharged many well-settled patients to general practitioners (GPs) but a few had expressed concerns and wanted to stay under my care. Some then decided to transfer to their GPs so long as I was able to convey necessary information in case of a crisis. This I did, although I had to reassure some of my GP colleagues that psychiatric services were always available if primary care arrangements were not sufficient.

I was unprepared for the sheer emotional turmoil in my out-patient (and in some cases in-patient) practice over those 6 months. Every clinic revolved around the subject of my departure, sometimes expressed in harrowing terms which left me moved and drained. Some patients were very keen to discover the reasons; they were concerned about my health, wanted to know if I was fed up with them, or simply wanted to look after 'easier' patients in another trust. A couple of patients wanted to settle old scores because they had been in disagreement with decisions I had taken many years earlier. Tears and pregnant angry silences were characteristic of these sessions. Even more difficult was to know how to respond to genuine expressions of affection and gratitude, or the giving of presents, or requests to organise leaving parties, or to put me forward for an OBE!

Many patients obviously needed to remain in mental health services and I started to prepare brief resumés for my successor. I had over 300 patients on my list, so this was not a small undertaking, but over the 6 months it did not prove to be too onerous. With hindsight, I wish I had shown patients their resumés, in order for them to agree or disagree with the contents and alter them if required.

Handing over

I prepared a short history of my tenure in the post for my successor, conveying the background and philosophy which had a bearing on my work. Consultant psychiatrists working in catchment areas are usually the longest-serving professionals in mental health teams, and as a result often represent and carry the historical link with the past. Linked with this I outlined everyday arrangements and practices, the nature of relationships within and outside the organisation, the current state of play and impending changes the consultant would have to face in the forthcoming year.

Negotiating my departure with consultant colleagues proved to be equally challenging. All expressed surprise at my decision but understood my reasons when I explained them. I could not, however, avoid the feeling that I was abandoning ship, and in that regard that I was betraying longstanding friendships and good working relationships, particularly at a time of considerable change and uncertainty. I had a similar reaction from my management colleagues with whom I had worked for many years. Inevitably, there were ambivalent feelings about my departure, and lots of jokes about me becoming a 'man of leisure'; 10 months on, this has not proven to be the case!

I was hoping to have a successor identified before I left. I gave what I thought was enough time to my clinical director to make arrangements to prepare new job descriptions, seek approval from the College, advertise and set up appointment committees. Since taking up my consultant appointment I have never witnessed smooth transitional arrangements whereby an overlap exists between predecessor and successor. Ever the optimist, I had hoped that I could succeed against the odds. The bureaucratic wheels in organisations turn so slowly, particularly when there are other changes afoot, that this proved impossible, and eventually a substantial appointment was made 6 months after I left, the job being filled by a succession of locums in the interim. Surely we must improve this state of affairs, which is so unsettling to patients and teams.

I would like to return to the special collaboration which I established with my secretary over the years. This paper cannot do justice to this complex relationship which, when working well, becomes so interdependent. By acting as an intermediary and voice-person, a good secretary carries a very considerable degree of the emotional load which arrives on the consultant's doorstep, and often has to manage it with subtlety, skill, forbearance and great patience. I had the privilege of such an association, and was not looking forward to it being severed. I could also tell that my secretary was

https://doi.org/10.1192/pb.bp.106.012419 Published online by Cambridge University Press

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particularly distressed at the notion of having to establish a new relationship with another consultant. Over the 6 months between my decision and my departure I had to rely heavily on her, not only to be at first hand when anxious queries arrived but also to help me with the convoluted administrative process required in the hand-over: what papers to chuck away, what to pass on, what to take away with me. At the same time, we tried to talk about my departure and manage our feelings about it, which was not an easy process of grieving and separation.

Likewise, I had to tackle the same issues with the dedicated members of the multidisciplinary team at the community mental health centre and the in-patient ward. Fortunately we had opportunities to ventilate our feelings, making strenuous attempts to ensure that the service to our patients remained as tight as possible during this time, and that we were singing from the same hymn sheet when patients asked about possible changes. Their steadfastness reassured me on two counts: my fears of a possible mass exodus after I left never materialised and I learned that I was not indispensable (even if at times I thought, or perhaps even wished, I was). The service would go on after I left.

Life goes on

Ten months on I have been fortunate to find some of the new ventures I was hoping for, even if when I started on this journey I had no clearly drawn maps with pre-assigned destinations. Among other things I am now working as a psychiatrist supporting a student counselling service in a large London University, offering support to children and family services in one of our deprived London boroughs, organising courses to help trusts prepare for the new Capacity Act, in different settings I am trying to improve standards of care in in-patient services and working as a second opinion doctor for the Mental Health Act Commission. Oh, I am also doing some painting and continue to sing in our choir. I have not had time to don my carpet slippers yet!

Writing this paper has helped me communicate with the 'other' part of me that still emotionally remains in the NHS. I am aware that many colleagues continue to work selflessly for the benefit of their patients, and I hope that this paper can be of some assistance to those who are contemplating embarking on new journeys. A list of 'take-home lessons' is given in Box 1.

Box 1. Take-home lessons

- If possible take time in coming to a decision and set yourself criteria which are relevant to you and which will help you weigh up your professional and personal priorities
- Talk to colleagues who have recently been through the experience
- If at all possible, give your patients sufficient advance notice once the date of your departure has been settled
- Use the opportunity of your leaving to discuss dependency issues with your patients
- Be prepared for the emotional upheaval that will be expressed by your well-known patients, and some acting out
- Give yourself time to produce helpful clinical resumés for your successor and share them with your patients, adding their comments and preferences
- Write a short history of your tenure for your successor, including details of service structure and practice, recent changes and future plans
- Give management sufficient time to advertise for your replacement and request a handover period
- Support your secretary during the process of separation and clarify precisely what needs to be communicated to patients about your departure
- Give yourself time to share feelings with colleagues.

Declaration of interest

None.

Acknowledgements

I am grateful to my friends Alberto Manguel and Dr Craig Stephenson for their comments on an early draft of this paper.

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https://doi.org/10.1192/pb.bp.106.012419 Published online by Cambridge University Press