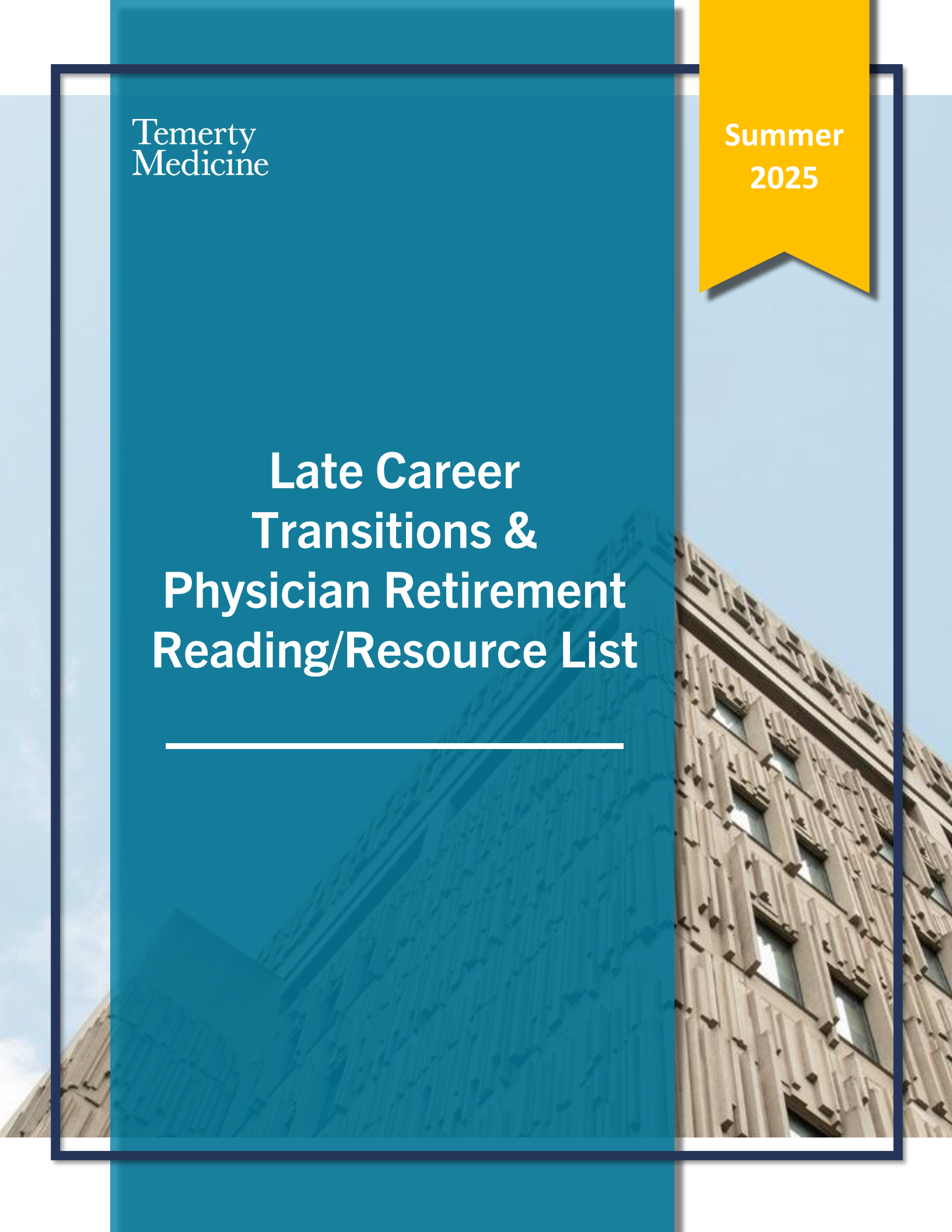
Temerty Medicine

Summer 2025

Late Career Transitions & Physician Retirement Reading/Resource List



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PREAMBLE

This document was prepared by a committee in the Temerty Faculty of Medicine (TFOM) – the Late Career Transitions and Retirement Planning Group – that was formed in May 2024. Our planning group includes representatives from both large and small departments in the TFOM. This initiative is funded by the TFOM and overseen by the Clinical Chairs Committee, the Wellness Program for Physicians, the Centre for Faculty Development (CFD), and Continuing Professional Development (CPD).

Our mandate is to empower, educate, and assist physicians regarding late career transitions, retirement, and beyond in the TFOM. We are also here to support Hospital Chiefs and University Department Chairs with developing and providing guidelines and support for physicians.

This reading list and other resources document is organized by medical specialty. We have also added articles on special topics including gender and competency issues and general issues for all physicians. We have recommended books of interest, podcasts, travel vloggers, websites, and added checklists and requirements for closing your clinical practice.

This document will be updated twice a year. We invite interested faculty to send us relevant articles, books, websites, podcast links, and travel vlog suggestions to Dr. Ivan Silver (ivan.silver@camh.ca).

We have organized a Community of Practice for late career physicians and other interested physicians to provide collegial opportunities for you to meet online to support your decision-making and plans for transitioning to retirement and to navigate this important phase of your career. For the academic year 2025-2026, we will host five online sessions starting in October 2025 and ending in May 2026. Stay tuned for further information regarding the specific dates.

We are writing a guidebook for physicians in the TFOM that will include enablers and barriers for transitioning and retirement, wellness and competence issues, a discussion of retirement and its impact on identity, what you can and cannot continue to do without a medical license, practical steps on closing your practice and recommendations for career, activities and wellness options in retirement. We also hope to provide a compendium of terminology used at U of T and in the Academic Hospitals with definitions, roles and responsibilities including part-time practice, courtesy staff, emeritus privileges, etc.

Please provide feedback on this document by writing Dr. Ivan Silver (ivan.silver@camh.ca).

ACKNOWLEDGEMENTS

We would like to express our gratitude to everyone who contributed to developing this reading/resource list. This list would not have been possible without the efforts and support of Temerty Faculty of Medicine's Office of Clinical and Faculty Affairs, the Centre for Faculty Development, UNH Medical Affairs, and the members of the Late Career Transitions and Retirement Planning Group:

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JOURNAL ARTICLES

ANESTHESIA

1. **The aging anesthesiologist.** J. D. Katz. Current opinion in anaesthesiology. 2016;29(2):206-211. https://dx.doi.org/10.1097/ACO.0000000000000299

   PURPOSE OF REVIEW: The average age of anesthesiologists in the USA is increasing. Advancing age is accompanied by challenges and opportunities to the individual anesthesiologist and his/her colleagues. This article will discuss the science behind policies to assure continued competence among these aging physicians and safety for their patients.

   RECENT FINDINGS: There is growing evidence that aging anesthesiologists may be advantaged by a lifetime of experience but possibly disadvantaged under certain circumstances by lapses in current medical knowledge contributing to medical errors. Policies and procedures are emerging to assist in evaluating the continued competence of aging physicians.

   SUMMARY: The average age of practicing anesthesiologists in the USA is increasing. As physicians continue to practice into later years, it is critical that innovative continuing medical education programs and objective evaluations of clinical skills and competence focused upon this group continue to be developed to assure public safety.

   http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26705128

2. **The ageing practitioner: ANZCA's recommendations.** A. B. Baker. Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists. 2016;24(2):151-154. https://dx.doi.org/10.1177/1039856215618527

   OBJECTIVES: The aim is to present recommendations of the Australian and New Zealand College of Anaesthetists (ANZCA) with respect to practice implications for ageing specialists, together with brief discussion of effects of ageing on professional medical capabilities and recommendations on preparing to retire from medical practice.

   CONCLUSIONS: Practitioners should recognise that planning for retirement is part of good management of a medical career, and that the ageing process will inevitably compromise their ability to treat patients safely unless they retire at the appropriate time. Planning should include adequate financial preparation, and cultivation of interests and friends outside medicine. Practitioners should also realise that insight is likely to be compromised, so that they should seek colleagues who are trusted to advise them if/when they begin to lose competency. Lastly all practitioners should ensure that they consult a General Practitioner frequently, and that they have arranged all the proper legal instructions such as a Will, a Power of Attorney and an Advanced Health Directive. The ANZCA recommendations concerning ageing specialists have wide application to all medical specialties, not just for anaesthetists, and therefore all Medical Colleges should generate their own specific recommendations for ageing practitioners and the general effects of fatigue particularly for aged practitioners. Copyright © The Royal Australian and New Zealand College of Psychiatrists 2015.

   http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26635370

3. **Successful navigation of late career transitions**. R. G. Cox. Paediatric anaesthesia. 2021;31(1):80-84. https://dx.doi.org/10.1111/pan.14037

   The purpose of this educational review was to describe the challenges that may face the anesthesiologist near the end of their career and to propose strategies that will enable the individual to continue to be a productive and valued member of their Department, both clinically and by other contributions.

4. **Bureaucracy is forcing GPs to quit under "euphemism of early retirement"**. A Rimmer. BMJ (Clinical research ed.). 2015;350:h2466. https://dx.doi.org/10.1136/bmj.h2466

   http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=25957397

5. **End-of-career practice patterns of primary care physicians in Ontario**. S Simkin, S Dahrouge and IL Bourgeault. Canadian family physician Medecin de famille canadien. 2019;65(5):e221-e230.

   OBJECTIVE: To characterize the process of end-of-career attrition among primary care physicians., DESIGN: Longitudinal, open cohort, population-based study of primary care physicians using health administrative data from ICES. Setting Ontario.

   PARTICIPANTS: All family physicians providing comprehensive care between 1992 and 2013.

   MAIN OUTCOME MEASURES: Changes in workload and scopes of practice over time.

   RESULTS: The cohort included 15 552 family physicians who provided comprehensive care at some point during the study period. Physicians reduced workloads and narrowed scopes of practice in advance of full retirement at an average age of 70.5 (95% CI 70.1 to 70.8) years. Female physicians provided fewer clinical services than male physicians did and retired 5 years earlier. Canadian medical graduates provided fewer clinical services and retired 2 years earlier than international medical graduates did. Up to 60% of physicians stopped providing comprehensive primary care before retirement, continuing with other clinical activities, at reduced workloads, for an average of 3 years before retiring fully.

   CONCLUSION: End-of-career practice patterns are characterized by gradual, modest changes in the provision of services rather than abrupt declines, and the retirement process unfolds differently for different physicians. This study highlights the importance of considering physician workload, scope of practice, and demographic factors for more accurate prediction of physician retirement trends and effective work force planning. Copyright© the College of Family Physicians of Canada.

   http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=31088888

6. **Exiting primary care providers**. K Zocher. Health Econ. 2024 May;33(5):1033-105. DOI: 10.1002/hec.4800

   This article studies the impact of primary care providers (PCPs) exit from the local health care system on patients' health care utilization. I compare patients with each other whose physicians have left the local health care system at different points in time due to retirement, relocation, or other reasons. Estimation results indicate that the imminent exit leads soon-leaving physicians to changing their treatment behavior, which has a significant impact on patients' health care spending. In addition, successors and new PCPs provide significantly more preventive services in the post-exit-period and refer patients more often to specialists for further examinations than the physicians who exit later. The increased inpatient expenditures in the post-exit period are caused by the new PCPs (through referrals). Self-initiated substitution behavior of patients (e.g., less PCP care, more

specialist care) after the exit is observed but is low in magnitude. Although an overall increase in health service utilization is observed, mortality in the post-exit periods is significantly increased among affected patients. A possible explanation is the low frequency follow-up care of patients who were referred to hospitals by their former PCP in the notification-period.

7. **Factors associated with plans for early retirement among Ontario family physicians during the COVID-19 pandemic: a cross-sectional study**. R Walsh, D Telner, DA Butt, P Krueger, K Fleming, S MacDonald, A Pyakurel, M Greiver, L Jaakkimainen. BMC Prim Care. 2024 Apr 18;25(1):118. DOI: 10.1186/s12875-024-02374-9

   Background: Higher numbers of family physicians (FPs) stopped practicing or retired during the COVID-19 pandemic, worsening the family doctor shortage in Canada. Our study objective was to determine which factors were associated with FPs' plans to retire earlier during the COVID-19 pandemic.

   Methods: We administered two cross-sectional online surveys to Ontario FPs asking whether they were "planning to retire earlier" as a result of the pandemic during the first and third COVID-19 pandemic waves (Apr-Jun 2020 and Mar-Jul 2021). We used logistic regression to determine which factors were associated with early retirement planning, adjusting for age.

   Results: The age-adjusted proportion of FP respondents planning to retire earlier was 8.2% (of 393) in the first-wave and 20.5% (of 454) in the third-wave. Planning for earlier retirement during the third-wave was associated with age over 50 years (50–59 years odds ratio (OR) 5.37 (95% confidence interval (CI):2.33–12.31), 60 years and above OR 4.18 (95% CI: 1.90-10.23)), having difficulty handling increased non-clinical responsibilities (OR 2.95 (95% CI: 1.79–4.94)), feeling unsupported to work virtually (OR 1.96 (95% CI: 1.19–3.23)) or in-person (OR 2.70 (95% CI: 1.67–4.55)), feeling unable to provide good care (OR 1.82 (95% CI: 1.10–3.03)), feeling work was not valued (OR 1.92 (95% CI: 1.15–3.23)), feeling frightened of dealing with COVID-19 (OR 2.01 (95% CI: 1.19–3.38)), caring for an elderly relative (OR 2.36 (95% CI: 1.69–3.97)), having difficulty obtaining personal protective equipment (OR 2.00 (95% CI: 1.16–3.43)) or difficulty implementing infection control practices in clinic (OR 2.10 (95% CI: 1.12–3.89)).

   Conclusions: Over 20% of Ontario FP respondents were considering retiring earlier by the third-wave of the COVID19 pandemic. Supporting FPs in their clinical and non-clinical roles, such that they feel able to provide good care and that their work is valued, reducing non-clinical (e.g., administrative) responsibilities, dealing with pandemic-related fears, and supporting infection control practices and personal protective equipment acquisition in clinic, particularly in those aged 50 years or older may help increase family physician retention during future pandemics.

8. **How do patients perceive the retirement of their general practitioner? A qualitative interview study in France**. Y Kerebel, T Duguet, A Kapassi, H Figoni, AL Colas-Charlap, L Pariente, F Perroteau, S Moussaoui, K Bonello, J Chastang. BMJ Open. 2024 Jun 16;14(6):e078166. DOI: 10.1136/bmjopen-2023-078166

   Objectives: The perspective of general practitioners' (GPs) on retirement and the factors influencing their attitude towards retirement have been previously investigated. However, while the number of GPs has been declining for many years in France, leading to the emergence of medical deserts, the

impact on their patients remains to be explored. The aim of this study was to understand patients' perceptions of their GP's retirement.

Design: A semistructured interview- based qualitative study was conducted, using Interpretative Phenomenological Analysis. Setting Interviews were conducted in two general practices located in Essonne, Ile- de- France, France, between January and April 2014. Participants Thirteen women and five men, aged 21–94 years, were included in this study. Exclusion criteria were the non- declaration of the physician as the declared doctor and being under 18 years of age.

Results: The GP–patient relationship is a link that is built up over time, over the course of several consultations. Patients choose their GP based on qualities or skills they value. In this way, the physician chosen is unique for their patients; this choice reflects a certain loyalty to their physician. The interaction with the family sphere reinforces this relationship through the multiple links created during care. When a GP retires, this link is broken. Patients' reactions can range from indifference to real grief.

Conclusion: This study confirms the importance of the link between the GPs and their patients and highlights the need to prepare patients for their GP's retirement.

9. **Job strain and retirement decisions in UK general practice.** J. Napier and M. Clinch. Occupational medicine (Oxford, England). 2019;69(5):336-341. https://dx.doi.org/10.1093/occmed/kqz075

BACKGROUND: Falling retention in UK general practice is a well-described problem but there has been little previous research into its underlying causes. Poor psychosocial work conditions may help explain falling workforce morale and early retirement from the profession.

AIMS: To explore the impact upon morale and retirement decisions of changes in psychosocial aspects of UK general practice over the course of a career., METHODS: Biographical narrative interviewing method (BNIM) was used to obtain and analyze career narratives of 12 London general practitioners (GPs), aged 55-65, half of whom had retired. Findings were theorized using the Job Demands-Control-Support (JDCS) model.

RESULTS: A spontaneous, consistent theme was evident across all 12 interviews: changes in the psychosocial work environment had contributed to a steady decline in morale. Sequential, multilayered reductions in autonomy were the most commonly cited causes for reduced enthusiasm. Increasing demands in the form of both a rising workload as well as a complaints culture drained energy and morale. The GPs described increasingly fragmented teams and therefore reduced social support for the role. Nonetheless, retirement decisions were not straightforward, provoking complex emotions.

CONCLUSIONS: The combination of increasing demands with reduced autonomy puts practitioners under intense strain, diminishing the satisfaction they derive from their work and affecting retirement decisions. The Job Demands-Control-Support (JDCS) model is an empirically tested model that could be used to inform improved work design in general practice.

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10. **Malpractice litigation, workload, and general practitioner retirement**. S Birkeland and SB Bogh. Primary health care research & development. 2019;20:e23. https://dx.doi.org/10.1017/S1463423618000816

    We investigated the association between general practitioner (GP) stress factors, including involvement in malpractice litigation or high workload levels during 2007 and ensuing retirement in a sample of Danish GPs. The case file and register information of 739 GPs were examined. Hazard ratios (HRs) were estimated for all causes of retirement from 2007 to 2016. During the study period, 34% of GPs had ceased to practice (n = 260). The HR for retirement was higher with increasing age (HR = 1.19 per year) and lower if practicing in a clinic with a greater number of GPs (HR = 0.47) but no statistically significant association was found between retirement and litigation or higher workload. Knowledge on factors influencing GPs' decision on whether to continue working is important to ensure sustainable primary care provision.

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11. **My Role in Health Care's Existential Crisis**. C Kommer. Annals of family medicine. 2022;20(6):566-567. https://dx.doi.org/10.1370/afm.2879

    Contemplating retirement after 38 years as a family physician has, for me, been an uncomfortably revealing process. I can't help but remember the few patient-care regrets that still upset me after all these years, and I find myself wishing I could go back in time; do things differently; conjure up better outcomes. I can't, of course, but those memories of individual patients eventually led me to consider my entire practice life, the legacy I might leave, and my role in a health care system that has changed so dramatically over the course of my career. Far too late, I have realized that while I was singularly focused on "taking care of patients," I neglected an even greater responsibility: to advocate for myself and my patients and push back against an endless series of misguided policy decisions that have adversely affected the health and well-being of my patients and made my job so much more difficult and stressful. American health care is experiencing an existential crisis, and I regret that it has happened "on my watch." By not speaking up as a physician, I enabled others to speak for me, others with far less knowledge, understanding, or commitment to patient care. I regret that most of all. In this article I try to come to grips with why I was mostly silent, and I share what I am trying to do now at the end of my career to effect change and find my voice. Better late than never, I am speaking up for my colleagues and patients. Now, more than ever, I hope that we physicians will insist on being heard.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=36443089

12. **Time to retire? A register-based study of GPs' practice style prior to retirement**. J O'Halloran, AS Oxholm, L. B. Pedersen and D. Gyrd-Hansen. Social science & medicine (1982). 2021;281:114099. https://dx.doi.org/10.1016/j.socscimed.2021.114099

    In many healthcare systems a large share of general practitioners (GPs) is retiring. The literature has shown a negative correlation between physicians' age and their quality of care. However, little is known about whether GPs exhibit different practice styles in the years prior to retirement. This

study investigates whether GPs who are closer to retirement make different professional choices than GPs who are not as close to retirement. Using detailed administrative data on 555 Danish GPs and their patients from 2005 to 2017, we study GPs' practice styles across a ten-year period prior to retirement and compare these with GPs who retire at a later date ('non-retiring GPs'), while controlling for age differences as well as exogenous factors affecting healthcare provision. We focus on the GPs' number of enlisted patients, revenue, provision of consultations, and treatment behaviour in consultations. We find no differences between retiring and non-retiring GPs for key outcomes such as 'revenue per patient' and 'consultations per patient'. However, we find that retiring GPs have fewer enlisted patients in their final years of practicing. This finding is driven by more patients leaving rather than fewer patients joining their lists. We also find that retirement is associated with other dimensions of GPs' practice style, e.g. their provision of home visits, prescribing, and referral rates. Overall, we find a modest association between GPs' retirement and their practice style.

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13. **Understanding the needs and concerns of senior faculty in academic medicine: building strategies to maintain this critical resource**. Stearns J, Everard KM, Gjerde CL, Stearns M, Shore W. Acad Med. 2013 Dec;88(12):1927-33. https://doi.org/10.1097/acm.0000000000000010.

14. **When Do Primary Care Physicians Retire? Implications for Workforce Projections.** S. M. Petterson, W. F. Rayburn and W. R. Liaw. Annals of family medicine. 2016;14(4):344-349. https://dx.doi.org/10.1370/afm.1936

    PURPOSE: Retirement of primary care physicians is a matter of increasing concern in light of physician shortages. The joint purposes of this investigation were to identify the ages when the majority of primary care physicians retire and to compare this with the retirement ages of practitioners in other specialties.

    METHODS: This descriptive study was based on AMA Physician Masterfile data from the most recent 5 years (2010-2014). We also compared 2008 Masterfile data with data from the National Plan and Provider Enumeration System to calculate an adjustment for upward bias in retirement ages when using the Masterfile alone. The main analysis defined retirement as leaving clinical practice. The primary outcome was construction of a retirement curve. Secondary outcomes involved comparisons of retirement interquartile ranges (IQRs) by sex and practice location across specialties.

    RESULTS: The 2014 Masterfile included 77,987 clinically active primary care physicians between ages 55 and 80 years. The median age of retirement from clinical activity of all primary care physicians who retired in the period from 2010 to 2014 was 64.9 years, (IQR, 61.4-68.3); the median age of retirement from any activity was 66.1 years (IQR, 62.6-69.5). However measured, retirement ages were generally similar across primary care specialties. Females had a median retirement about 1 year earlier than males. There were no substantive differences in retirement ages between rural and urban primary care physicians.

    CONCLUSIONS: Primary care physicians in our data tended to retire in their mid-60s. Relatively small differences across sex, practice location, and time suggest that changes in the composition of the

primary care workforce will not have a remarkable impact on overall retirement rates in the near future. Copyright © 2016 Annals of Family Medicine, Inc.

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15. **When It's Time to Retire: Notes From the Afterlife.** D. Loxterkamp. Annals of family medicine. 2018;16(2):171-174. https://dx.doi.org/10.1370/afm.2204

    At the end of the Second World War, the US birth rate peaked at nearly 27 births per 1,000 population-a rate unparalleled in the previous 3 decades, and one that would not be repeated. That Boomer generation is now retiring. How do those of us caught in the wave feel about stepping back? Who will step in to replace us? And how will we replace the loss of purpose and fulfillment that comes from a career in medicine? A lengthening life expectancy has challenged many of us to consider the "second act" to our adult life. This essay describes the emotional turbulence of ending one career and contemplating the next. Copyright © 2018 Annals of Family Medicine, Inc.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=29531112

MEDICINE

16. **Conversations in cardiology-When to tell an interventionalist to retire.** M. J. Kern. Catheterization and cardiovascular interventions: official journal of the Society for Cardiac Angiography & Interventions. 2019;94(1):136-138. https://dx.doi.org/10.1002/ccd.28273

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=30993843

17. **Financial planning and satisfaction across life domains among retired emergency physicians in the United States**. G. J. Kuhn, C. A. Marco, M. N. S. Mallory, M. Blanda, J. A. Kaplan, S. M. Schneider, K. B. Joldersma, S. I. Martin and E. K. Choo. The American journal of emergency medicine. 2018;36(3):508-510. https://dx.doi.org/10.1016/j.ajem.2017.06.059

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=28784258

18. **Is It Time to Retire?**. W. Levinson and S. Ginsburg. JAMA. 2017;317(15):1570-1571. https://dx.doi.org/10.1001/jama.2017.2230

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28418486

19. **The Occupational Medicine Physician: Planning for and Transitioning into Retirement**. WN Burton, GM Stave, CM Baase, RJL Heron, R Thirumalai. J Occup Environ Med. 2024 May 1;66(5):372-374

    Occupational medicine physicians (OMPs) spend the first phase of their career in education and training and the second phase working. With increasing lifespans, a third phase may extend over a long timeframe. In this issue of the journal, Stave et al report the results of an international survey of almost 500 OMPs on their preparations, plans, and interests as they consider the transition to retirement. Only about a quarter of OMPs aged 31 to 40 years had written financial plans, increasing to slightly more than 50% among those aged 51 to 60 years. Overall, only 35% indicated that they were very comfortable with their retirement plans. At the same time, survey respondents expressed a high interest in remaining engaged after leaving full-time (FT) work with 85% planning to pursue part-time (PT) work. Almost half want to work as consultants, one quarter want to work as part-time medical directors, and many expressed interest in work in a variety of other settings. In addition, 60% want to participate in a variety of volunteer activities. The respondents were also very interested in learning about compensated and uncompensated opportunities after leaving FT work.

    Planning for a successful career during the FT working phase should also include preparing for a successful retirement. Occupational medicine physicians develop a broad skill set, which creates opportunities to engage in a wide variety of paid and uncompensated activities during and after FT work. These activities also contribute to an OMP's flourishing, which includes the domains of meaning and purpose, and close social relationships. Physicians typically have much of their identity tied to their professional role and work. Many have a deep sense of purpose and may see their work as a calling. Their social network is often predominantly tied to their network of professional colleagues. In addition, to prepare for their future, OMPs should pursue financial planning and continue to develop the skills and relationships that will allow them to engage in the activities that interest them.

20. **Occupational Medicine Physicians Transition to Retirement: An International Survey of Preparation, Plans, and Interests.** GM Stave, WN Burton, RJL Heron, CM Baase and R Thirumalai. J Occup Environ Med. 66(5):p 366-371, May 2024. DOI: https://dx.doi.org/10.1097/JOM.0000000000003053

    OBJECTIVE: To understand the needs and interests of occupational medicine physicians (OMPs) as they transition to retirement.

    METHODS: An electronic survey was distributed through member organizations in the US (ACOEM), UK (SOM/FOM), India (IAOH), South Africa (SASOM), and Medichem.

    RESULTS: 497 OMPs at various career stages responded, including 282 from the US, 97 from the UK, 36 from India, 30 from South Africa, and 52 from other countries. 278 work full-time, 160 part-time, and 58 are not doing paid work. ~60% serve as volunteers. 60% have a written financial plan. 35% are very comfortable with their retirement plans. After leaving full-time work, 85% plan to work part-time. There is a high level of interest in learning about opportunities for part-time work and volunteering.

    CONCLUSIONS: OMPs are very interested in learning more about compensated and uncompensated work in retirement. Copyright © 2024 American College of Occupational and Environmental Medicine.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=medp&NEWS=N&AN=38242536

21. **Planning for retirement from medicine: a mixed-methods study**. M. P. Silver and L. K. Easty. CMAJ open. 2017;5(1):E123-E129. https://dx.doi.org/10.9778/cmajo.20160133

    BACKGROUND: Evidence suggests there are important personal and social consequences associated with inadequate retirement planning for physicians. We evaluated whether academic physicians felt satisfied with their retirement planning, and identified obstacles to retirement planning and a set of factors to facilitate retirement planning.

    METHODS: We applied a sequential mixed-methods research design to explore and examine factors that facilitate academic physician retirement planning using data collected from multiple sources (including 7 focus groups, an internet-based survey and 23 in-depth interviews). We examined survey results regarding retirement planning satisfaction and preferences for complete versus gradual retirement. We used thematic analysis to examine verbatim transcripts and notes from the focus groups and interviews.

    RESULTS: Survey data (response rate 51%) indicated that 10% of respondents were very satisfied with their retirement planning and 89.5% would prefer to retire gradually rather than stop work completely. Key barriers to retirement planning that emerged included poor personal financial management, rigid institutional structures and professional norms. Facilitators included financial planning resources for physicians at multiple career stages, opportunities and resources for later-career transitions and later-career mentorship support for intergenerational collaboration, and recognition of retirees.

INTERPRETATION: Key findings highlight perceived barriers to retirement planning at various career stages in addition to factors that can enhance physicians' retirement planning, including creating gradual and flexible retirement options, supporting ongoing discussions about financial planning and later career transitions, and fostering a culture that continues to honor and involve retirees. Medical institutions could foster innovative models for later-career transitions from medicine in ways that address physicians' needs at various career stages, support gradual transitions from practice and recognize the value of experienced, capable later-career physicians and retirees.

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22. **Retirement: An idiosyncratic vade mecum**. R. I. Rudolph. Clinics in dermatology. 2020;38(5):537-540. https://dx.doi.org/10.1016/j.clindermatol.2020.05.010

    Many physicians tend to regard their upcoming retirement with great trepidation. They are worried that after years of productive activity they will become useless and lose all their connections with medicine. This essay will try to impress on readers that this way of thinking is absolutely incorrect, and it will provide some personal insights regarding the retirement process. These will address why I retired (due to governmental interference), how I felt before I retired (pretty lousy), and how I felt after closing my practice (really liberated). I've also included some thoughts on how to minimize aggravation when shuttering a practice, as well as suggestions on how to remain active in medicine. Some reflections on staying fulfilled during postretirement are presented, ranging from making an effort to teach colleagues and young physicians (the most important project), lots of omnivorous reading (the second most important pastime), continuing medical writing, trying to travel, taking up cooking (truly marvelous!), and generally attempting to fully enjoy the leisure time afforded upon leaving practice. The bottom line is that retirement is not to be dreaded or feared but rather anticipated and enjoyed. For me, it has turned out to be simply delightful and wonderful.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med18&NEWS=N&AN=33280800

23. **To Retire or Not? That Is the Question**. M. L. DeBard. Annals of emergency medicine. 2015;66(4):428-429. https://dx.doi.org/10.1016/j.annemergmed.2015.02.007

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26398172

OBSTETRICS AND GYNECOLOGY

24. **Considerations about retirement from clinical practice by obstetrician-gynecologists**. W. F. Rayburn, A. L. Strunk and S. M. Petterson. American journal of obstetrics and gynecology. 2015;213(3):335.e331-334. https://dx.doi.org/10.1016/j.ajog.2015.03.027

    Retirement of obstetrician-gynecologists is becoming a matter of increasing concern in light of an expected shortage of practicing physicians. Determining a retirement age is often complex. We address what constitutes a usual retirement age range from general clinical practice for an obstetrician-gynecologist, compare this with practitioners in other specialties, and suggest factors of importance to obstetrician-gynecologists before retirement. Although the proportion of obstetrician-gynecologists >=55 years old is similar to other specialists, obstetrician-gynecologists retire at younger ages than male or female physicians in other specialties. A customary age range of retirement from obstetrician-gynecologist practice would be 59-69 years (median, 64 years). Women, who constitute a growing proportion of obstetrician-gynecologists in practice, retire earlier than men. The large cohort of "baby boomer" physicians who are approaching retirement (approximately 15,000 obstetrician-gynecologists) deserves tracking while an investigation of integrated women's health care delivery models is conducted. Relevant considerations would include strategies to extend the work longevity of those who are considering early retirement or desiring part-time employment. Likewise volunteer work in underserved community clinics or teaching medical students and residents offers continuing personal satisfaction for many retirees and preservation of self-esteem and medical knowledge.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=25794630

25. **Retirement Age Ranges from Clinical Practice of Maternal-Fetal Medicine Physicians**. B. D. Holbrook, S. M. Petterson and W. F. Rayburn. American journal of perinatology. 2017;34(5):499-502. https://dx.doi.org/10.1055/s-0036-1593537

    Objectives: Retirement of "baby boomer" physicians is a matter of growing concern in light of the shortage of certain physician groups. The objectives of this investigation were to define what constitutes a customary retirement age range of maternal-fetal medicine (MFM) physicians and examine how that compares with other obstetrician-gynecologist (ob-gyn) specialists.

    Study Design: This descriptive study was based on American Medical Association Masterfile survey data from 2010 to 2014. Data from the National Provider Identifier were used to correct for upward bias in reporting retirement ages. Only physicians engaged in direct patient care between ages 55 and 80 years were included. Primary outcomes involved comparisons of retirement ages of male and female physicians with other ob-gyn specialties.

    Results: Interquartile ranges of retirement ages were similar between specialists in MFM (64.1-71.1), gynecologic oncology (62.1-68.9), reproductive endocrinology and infertility (64.1-71.7), and general ob-gyn (61.5-67.9). In every specialty, women retired earlier, while males in MFM were most likely to retire at the oldest age (median 70.0).

Conclusion: MFM physicians usually retired from clinical practice between ages 64 and 71 years, which is similar to other ob-gyn specialists. Females retired earlier, however, which may impact the overall supply as more females pursue MFM careers. Copyright Thieme Medical Publishers.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=27732985

OTOLARYNGOLOGY – HEAD AND NECK SURGERY

26. **Impact of the COVID-19 Pandemic on Retirement Among Canadians Otolaryngoloists**. Sahlollbey N, Vijay A, Carr MM. Journal of Otolaryngology: Head and Neck Surgery. 54:19160216251321458, 2025 Jan-Dec. https://dx.doi.org/10.1177/19160216251321458

Introduction: Otolaryngologists were among the physicians with the highest risk of exposure to SARS-CoV-2, and more than half of them reported anxiety and distress during the pandemic. Consequences of this experience on retirement plans among otolaryngologists are unknown. This study aimed to describe the effect of the pandemic on retirement plans among otolaryngologists.

Methods: A cross-sectional survey assessed retirement plans of physicians in the Canadian Society of Otolaryngology-Head and Neck Surgery (CSOHNS) between May and June 2023. Participants were recruited through CSOHNS membership lists. Respondents shared demographic information and rated 4 pandemic-related factors and 13 independent factors on a 5-point Likert scale from least important to most important in influencing retirement.

Results: Eighty-two members responded, of which 20 (24.4%) were females. All female participants were 65 or younger, whereas 25 (40.3%) males were 65 or older. Half of the participants were in academic practice; 39% reported no change to their anticipated retirement date prior to the pandemic, whereas 25% reported either earlier or later dates. A greater proportion of female otolaryngologists reported earlier dates of retirement than originally planned compared with males (40% vs 19.3%). The factors most commonly rated as "important" were the desire for time with loved ones (mean: 3.82, SD: 1.179), the desire to improve their quality of life (mean: 3.65, SD: 1.344), and increased workload (mean: 3.26, SD: 1.210). Significant differences were observed between genders and age groups (<=55 years vs >55 years) regarding increased workload, desire for improved quality of life, personal and loved ones' health concerns, pandemic-related concerns, psychological/emotional issues, and burnout ($P < .05$). Conclusions Pandemic-related factors play a limited role in retirement decisions made by otolaryngologists. More females reported earlier retirement dates after the pandemic, which may further exacerbate preexisting gender inequalities in the otolaryngology workforce.

PAEDIATRICS

27. **Career transitions in the third age: A study of women pediatricians**. J. Livingston. Dissertation Abstracts International Section A: Humanities and Social Sciences. 2018;79(2-A(E)):No-Specified.

In this qualitative interview study, I explored how eight women pediatricians, ages 61-72, considered and experienced career transitions, including but not limited to retirement transition, and the influence of career transitions on their development. These women are in the third age which has been defined as a period when people are looking for what comes next as they anticipate living longer and consider some form of retirement. I chose to focus on women pediatricians, in part, because of concerns of an aging pediatric workforce which has a high percentage of women. A better understanding of their career transitions can help inform policies on workforce issues, as well as aid third age women pediatricians and other professional women in making transitions where they can continue to use their talents and foster development. The interview data were analyzed using Nancy Schlossberg's 4 S model of transition (Anderson, et al., 2012) and gendered life course theory (Moen, et al., 2009), with the epistemologies of interpretivism, social constructionism, and existential feminism underpinning my study. Findings indicated that study participants' career transitions emanated from a gendered life course where strategic selections were made in the context of medical culture. They enacted the dominant medical culture, submitting to its terms as required while making significant personal and professional sacrifices in order to participate in their profession. Study participants also subverted the dominant medical culture. They imbued an ethic of care and compassion into their medical practice, with an understanding and appreciation for the relational and bringing feminine consciousness to their work. In their career transitions, they mourned the loss of relationship and human touch in their medical practice through the drudgery of electronic medical records technology and other system changes they perceived as altering a vocation to merely a career. Study participants were in strong positions moving in, through, and out of their anticipated transitions, with ample resources in all four components of the 4 S model. Career transitions were based on commitment to spouse and family and a desire to continue meaningful work found in their calling as caregivers. Control of schedule and self-determination about work were key factors in study participants' career transitions. Continuity of identity and role loss influenced transitions where all had pre-bridging strategies that helped mitigate transition effects. All found ways to retain a connection to medicine, even after retiring from clinical practice, although in one case not lasting. Study participants bridging to retirement and those retired were most affected by anxiety about and actual role loss. Some experienced being marginalized due to role loss, which led to sadness. Those still working were focused on transitions to work indefinitely; a means to avert role loss. Their transitions were also aimed at continuing work at a slower pace and demonstrated that, even in high intensity work, there are transition pathway options for full-time employment. The desire for authenticity, introspection, and the inner work of individuation were associated with higher age rather than retirement status. My study findings support calls for structured, institutionalized policies and processes that facilitate third age pediatricians' career transitions where they can continue doing meaningful work, compensated or uncompensated, connected to their profession (Hall, 2005, 2013; Silver, et al., 2016). Temporal flexibility and self-determination that support work and family life balance are important elements for these considerations, as is the role of social convoy. (PsycInfo Database Record (c) 2022 APA, all rights reserved)

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc17&NEWS=N&AN=2018-00724-280

28. **Factors Influencing Pediatrician Retirement: A Survey of American Academy of Pediatrics Chapter Members**. M. E. Rimsza, H. Ruch-Ross, H. K. Simon, T. W. Pendergass and H. J. Mulvey. The Journal of Pediatrics. 2017;188:275-279. https://dx.doi.org/10.1016/j.jpeds.2017.05.043

    OBJECTIVE: To assess the factors that may influence physicians' desire to retire through an analysis of data collected through the American Academy of Pediatrics (AAP) State Pediatrician Workforce Survey.

    STUDY DESIGN: An electronic survey was sent to retired and nonretired US pediatricians who held AAP membership. The respondents were asked about the importance of 12 factors that would influence or had influenced their decision to retire. The physicians who were not yet retired also were asked: "If you could afford to today, would you retire from medicine?"

    RESULTS: The survey was completed by 8867 pediatricians. Among the nonretired respondents, 27% reported that they would retire today if it were affordable. Increasing regulation of medicine, decreasing clinical autonomy, and insufficient reimbursement were rated as very important factors by >50% of these pediatricians. Among retired pediatricians, 26.9% identified the effort to keep up with clinical advances and changes in practice as a very important factor in their decision to retire. Younger physicians were significantly more likely to rate maintenance of certification requirements, insufficient reimbursement, lack of professional satisfaction, and family responsibilities as very important factors. Rural pediatricians were more interested in retiring than those working in academic settings. There were no sex differences.

    CONCLUSIONS: Twenty-seven percent of pediatricians in practice today would retire today if it were affordable. Identifying and addressing the important factors that influence a pediatrician's desire to retire can potentially reduce the retirement rate of pediatricians and thus increase access to care for children.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28606370

29. **Late-Career Pediatric Hospitalists: Programmatic Accommodations and Supports**. J. Weiss, S. Gage, J. Kusma and L. Mirea. Hospital pediatrics. 2022. https://dx.doi.org/10.1542/hpeds.2021-006190

    BACKGROUND: As the number of late-career pediatric hospitalists increases, issues regarding aging and retirement will require more attention. Long shifts and overnight clinical responsibilities may be challenging for older physicians. Our study objectives include investigation of the current state of practice regarding work hours, night call responsibilities, productivity requirements, coronavirus disease 2019 (COVID-19) exposure modifications, and division chief knowledge about retirement supports for late-career pediatric hospitalists.

    METHODS: This cross-sectional study used a web survey, distributed in spring of 2020 on the American Academy of Pediatrics, Section on Hospital Medicine, Division Chief listserv. The questionnaire asked about (1) program demographics, (2) overnight call responsibilities, (3) clinical schedules, (4) modifications for COVID-19, and (5) retirement benefits and supports. Data were analyzed by using descriptive statistics and the Fisher exact test.

RESULTS: The 47 responding programs employ 982 hospitalists in 728 full-time equivalent positions. Division chiefs estimated 117 (12%) individuals were aged 50 to 64 years and 16 (1.6%) were 65 years or older. Most programs (91%) had at least 1 member 50 to 64 years of age; 13 programs (28%) had a member aged 65 or older. Larger programs were more likely to allow older physicians to opt out of some night call responsibilities. Most programs made some accommodations for COVID-19 exposure. Other than financial counseling and academic benefits, most programs did not provide retirement counseling or other supports for retiring physicians.

CONCLUSION: Although limited by a low response rate, we found most programs had older faculty. Substantial variation exists in how programs make accommodations and offer support for older members. Copyright © 2022 by the American Academy of Pediatrics.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=medp&NEWS=N&AN=35199153

30. **Retiring From Pediatric Emergency Medicine Too Soon?: A Survey to Discover the Reasons and Start a Conversation About Solutions**. B. B. Bansal, M. S. Mathew, Q. Booker-Nubie, S. E. Messiah and V. J. Wang. Pediatric emergency care. 2022;38(6):253-257. https://dx.doi.org/10.1097/PEC.0000000000002697

OBJECTIVE: Pediatric emergency medicine is a subspecialty known for high acuity, high stress, and variable scheduling that may be difficult to maintain as one gets older. This survey sought to gain information on the reasons or plans for early retirement in pediatric emergency medicine and offer ways to address these concerns to improve longevity in the field.

METHODS: A cross-sectional survey was sent via email to board-certified pediatric emergency medicine physicians who were older than 50 years to assess preretirement and postretirement considerations. Results were collected from October 3, 2019, through March 15, 2020.

RESULTS: Pediatric emergency medicine physicians who find it more difficult to perform simple procedures are 3.02 (1.23-7.36) times more likely to retire before the age of 66 years. In addition, women were significantly more likely to report an intention to retire before the age of 66 years versus men (50% vs 31%, P = 0.022).

DISCUSSION: The topic of retirement in a field that requires a wide range of procedural skills as well as constantly evolving technology is important. Understanding when and why physicians choose to retire may identify strategies to make it possible for pediatric emergency medicine physicians to prolong their careers. This may involve changes in work hours, a shift in responsibilities to a greater educational or mentor role, and/or providing opportunities to maintain skills.

CONCLUSIONS: Perceived basic procedure skills deterioration significantly increased the risk for early retirement. In addition, women were significantly more likely to express intention to retire before the age of 66 years. Further research should be directed toward obtaining more detailed information to develop strategies to retain pediatric emergency medicine physicians in a capacity that benefits the physician, their institution, and their patients. Copyright © 2022 The Author(s). Published by Wolters Kluwer Health, Inc.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=35639430

31. **Why Do Pediatricians Retire?**. R. W. Steele. Clinical pediatrics. 2015;54(14):1309-1310. https://dx.doi.org/10.1177/0009922815588823

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26016837

PSYCHIATRY

32. **Accepting the challenges of ageing and retirement in ourselves: The need for psychiatrists to adopt a consensus approach**. C. Wijeratne and C. Peisah. Australian and New Zealand Journal of Psychiatry. 2013;47(5):425-430. https://dx.doi.org/10.1177/0004867413477220

    The Australasian psychiatric workforce is ageing. Data from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) shows that 42.2% of approximately 2950 Fellows practicing in Australia are aged 55 years and older, including 17.7% aged 65 years and older, suggesting that a number of psychiatrists are working into their 70s and 80s. The equivalent proportions for the 320 RANZCP Fellows working in New Zealand are 42% and 14.4%, respectively. The need to address such issues is equally relevant and pressing for an ageing psychiatric workforce. While we do argue for a similar set of guidelines to be considered by the RANZCP, it is recognized that the specific cognitive and other skills required for the practice of psychiatry would vary from those applied by procedural specialists. There are three reasons why each psychiatrist should continue working for as long as practicable. The first is workforce planning and service provision. The current Australian ratio of approximately one psychiatrist per 9000 people is favorable when compared with the World Health Organization recommendation. The second reason to encourage retention of psychiatrists is that late career psychiatrists provide a valuable service to the profession. RANZCP Fellows, in particular younger and early-career psychiatrists, believe that senior psychiatrists have 'wisdom' to offer junior colleagues, in particular mentoring and supervision, life experience and acceptance of personal limits/fallibility. The third reason is that each individual medical practitioner has the right to continue working, as long as the primary ethical principle of doing no harm to the patient, profession and wider society is observed. Psychiatrists, of all medical specialists, should be most aware of the benefits of work to psychological well-being. While the social, workforce and personal benefits of continuing to work are clear, psychiatrists need to be aware of the potential for age-related changes to cognition, performance, physical and psychological health that affect the capacity to practice safely. A number of preventative measures need to be considered. In the absence of dialogue or systemically ratified guidelines regarding an ageing workforce, there is apathy within the profession regarding support for late-career psychiatrists, workplace adaptations, retention strategies or retirement planning. The most catastrophic consequence of this lack of thought-represented by those psychiatrists who are identified as impaired-occurs in patients who may be harmed. It must also be recognized that colleagues and the practitioner's family will also bear the burden of an impaired practitioner or the sudden retirement of a practitioner. (PsycInfo Database Record (c) 2022 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc12&NEWS=N&AN=2013-16297-006

33. **The aging psychiatrist: lessons from our colleagues in surgery and anaesthesia**. B. P. Waxman. Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists. 2016;24(2):155-156. https://dx.doi.org/10.1177/1039856216632401

    OBJECTIVES: The Royal Australasian College of Surgeons (RACS) has been innovative in developing core competencies, which provide a framework for assessing performance and a 'Code of Conduct', for the lifelong journey of all surgeons. The older surgeon may face significant challenges, having passed their peak, with a lower volume of cases, and potentially increased complications. They also

face the challenges of retiring from active clinical practice with its logistical and psychological dilemmas. The RACS has, therefore, put in place several initiatives to deal with these dilemmas.

CONCLUSIONS: The Senior Surgeons' Group, which conducts annual 'Building Towards Retirement' workshops, has been the driving force behind these initiatives. The group has a regular program in the RACS Annual Scientific Congress, including the multidisciplinary session 'The ageing specialist - challenges for regulators: hypothetical' which took place in 2014, and some of its members are part of a multidisciplinary team with an approach to adapting to ageing that encourages self-reflection and self-monitoring. It has also influenced the RACS Council to change the continuing professional development (CPD) regulations to include requirements for ageing surgeons regards health maintenance, peer reviews, and modified requirements to satisfy CPD completion. The RACS offers a variety of other opportunities for the ageing surgeon to remain active in college activities. Copyright © The Royal Australian and New Zealand College of Psychiatrists 2016.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26912470

34. **Closing up and moving on: A personal perspective of psychiatric practice closure**. D. Neill. Australasian Psychiatry. 2016;24(2):134-139. https://dx.doi.org/10.1177/1039856215620028

    OBJECTIVES: This paper sets out a process for the elective closure of a clinical practice. The details are described for a particular example of a practice closure. The common elements to all practice closures are identified. A range of other factors which may be relevant to other practice closure circumstances are also listed and the literature is referenced.

    CONCLUSIONS: The closure of a clinical practice is a major stage in professional life and merits preparation, support and accessible resources. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc15&NEWS=N&AN=2016-14102-005

35. **Graceful ageing for the career psychiatrist**. A. Amos. Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists. 2016;24(2):124-125. https://dx.doi.org/10.1177/1039856216636511a

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26994270

36. **How Senior Psychodynamic Psychiatrists Regard Retirement**. D. H. Ingram and J. Stine. Psychodynamic psychiatry. 2016;44(2):211-237. https://dx.doi.org/10.1521/pdps.2016.44.2.211

    The variety of personal experiences and attitudes about professional work among psychodynamic psychiatrists who have attained retirement age are explored through semi-structured interviews. Of 21 members of the American Academy of Psychoanalysis and Dynamic Psychiatry interviewed, 6 report fulltime engagement in professional activity, 10 partial reduction, and 5 full retirement from practice. Through direct quotations from the respondents' interviews several matters are considered including the concept of retirement, structural changes in practice, health concerns, dream experience, spirituality and matters of legacy, how others have influenced attitudes toward

continued work, and how fears of retirement are manifest among those currently in practice. Among the conclusions is the suggestion that the sense of self-regard and personal satisfaction of those who do retire is far greater than anticipated by those still in active practice.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=27200463

37. **Later life transitions and changes in psychiatry**. J. A. Randles. Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists. 2016;24(2):148-150. https://dx.doi.org/10.1177/1039856216634820

    OBJECTIVE: The objective of this study was to discuss some concerns that today's psychiatrists are likely to experience in the later stages of their careers.

    CONCLUSIONS: When changes associated with ageing begin to make their presence felt, there is a need to come to terms with them. For many psychiatrists this may generate a surprising creativity. Psychiatrists also need to come to terms with a paradigm change that has taken place in psychiatric practice. This paper, one of a series that captures a broad perspective on ageing, was solicited (by the Members Engagement Committee) to specifically capture the psychotherapist's view of later life transitions. Copyright © The Royal Australian and New Zealand College of Psychiatrists 2016.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26906440

38. **A personal perspective from the UK: ageing and psychiatrists**. S. M. Benbow. Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists. 2016;24(2):131-133. https://dx.doi.org/10.1177/1039856215620026

    OBJECTIVE: Psychiatrists appointed to National Health Service (NHS) consultant posts in the United Kingdom before a specific date in 1995 qualified for early retirement and this has implications for workforce planning.

    METHODS: The author reflects on the implications this has for ageing psychiatrists and for relationships between psychiatrists and patients and families using mental health services, from the perspective of a psychiatrist who took advantage of the opportunity to retire early from a consultant post in the NHS and to develop a new career.

    RESULTS: Older psychiatrists continuing to practice after retirement from consultant roles may bring disadvantages and advantages.

    CONCLUSIONS: Older psychiatrists may be a valuable resource for future mental health services, and they may be in a position to try out new ways of working which might be relevant to their younger colleagues in the uncertain future faced by mental health services at a time of austerity. Copyright © The Royal Australian and New Zealand College of Psychiatrists 2015.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26635372

39. **A psychiatrist retires: An oxymoron?**. N. A. Clemens. Journal of Psychiatric Practice. 2011;17(5):351-354. https://dx.doi.org/10.1097/01.pra.0000405365.97666.5d

The author examines the various factors that a psychiatrist may consider in making the decision whether or when to retire. These include one's professional persona, the prevailing professional culture, attachment to patients, practice situation, age, health, family situation, finances, other interests, other professional commitments, adaptability, and more. Personal experience and the limited literature indicate that the prevailing psychiatric professional culture is averse to retirement, but this may vary with changing practice patterns. The decision is a highly individual one that calls for much thought and preparation. This is the first of two articles dealing with retirement. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc10&NEWS=N&AN=2011-21480-006

40. **A psychiatrist retires: The happening**. N. A. Clemens. Journal of Psychiatric Practice. 2011;17(6):725-728. https://dx.doi.org/10.1097/01.pra.0000407966.72722.39

    The author uses his own recent experience as a basis for discussing the actualities of retiring and closing a private, solo, psychiatric practice of psychotherapy and psychoanalysis. The extended process includes a personal decision about whether, when, and how to retire; preparation of patients and arrangements for their ongoing care; dealing with legal requirements and professional obligations; and the mechanics of closing an office one has occupied for decades. Not the least of concerns is one's own personal transitions in lifestyle, professional persona, attachments to patients, and engagement in psychotherapeutic or psychoanalytic treatment relationships. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc10&NEWS=N&AN=2011-27555-007

41. **A Retired Psychiatrist on Retirement: Rejoicing Jubilatio**. J. C. Corvalan. Missouri medicine. 2022;119(5):408-410.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=36338006

42. **Transitions to retirement**. K. Jenkins. Australasian Psychiatry. 2016;24(2):123-124. https://dx.doi.org/10.1177/1039856216636511

    This editorial provides an overview of the papers presented in the issue Australasian Psychiatry. This issue brings together a collection of articles pertinent to aging for us as doctors, and the transitions that face (or will face) all of us when considering "winding down", "cutting back" or retiring from practice. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc15&NEWS=N&AN=2016-14102-001

RADIOLOGY

43. **Developing a Late-Career Roadmap to Continued Career Engagement.** T. Catanzano, N. Verma, D. Sarkany, T.-L. Mohammed and P. J. Slanetz. Academic radiology. 2023;30(11):2757-2760. https://dx.doi.org/10.1016/j.acra.2023.04.012

    Professional development needs span the entirety of a radiologist's career. Great strides have been made in the creation of an infrastructure for early career development. Work is ongoing to develop such resources for mid-career radiologists, given the recent recognition of the needs of this group. Unfortunately, even less attention has been paid to late-career radiologist development needs as a bridge to retirement. As part of the Career Conversations series, this article will highlight the needs and currently available resources for this group. Copyright © 2023. Published by Elsevier Inc.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med24&NEWS=N&AN=37758585

44. **The Late-Career Radiologist: Options and Opportunities**. E. I. Bluth, T. R. Goodman and C. E. Bender. Radiographics: a review publication of the Radiological Society of North America, Inc. 2018;38(6):1617-1625. https://dx.doi.org/10.1148/rg.2018180015

    More than 25% of the present radiology workforce, or nearly 8300 radiologists, are actively practicing late-career radiologists. While these individuals could decide to retire from active practice, their continued presence in the workforce helps to maintain adequate and appropriate patient imaging services. To ensure their continued participation, issues important to all late-career radiologists need to be appreciated, discussed, and addressed. These issues include call-duty requirements, compensation, physical and cognitive health, and organized phase-out programs. The gamut of these issues is addressed in this review article. ©RSNA, 2018.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=30303783

45. **Making the Most of the Golden Years-Transitions and Opportunities**. Slanetz P.J., Magid D., Everett C.J., Deitte L.A. Journal of the American College of Radiology. 22(6) (pp 701-703), 2025. Date of Publication: 01 Jun 2025. https://dx.doi.org/10.1016/j.jacr.2024.11.022

46. **Retirement issues for radiologists: consensus statement on successful planning by the Commission on Human Resources of the ACR**. E. M. Donner, 3rd, G. Sze and E. I. Bluth. Journal of the American College of Radiology : JACR. 2015;12(3):235-238. https://dx.doi.org/10.1016/j.jacr.2014.10.019

    Successful retirement planning requires a determination of which activities and relationships may replace those associated with the current full-employment position. Next, there must be acceptance of leaving the profession behind. Finally, the individual must determine the specific decisions and actions that must be made to transition to successful retirement in the future. To be successful, the entire process should occur over a period of several years. Alternatively, bridge employment may play a significant role in the transition from full employment to full-time retirement. Copyright © 2015 American College of Radiology. Published by Elsevier Inc. All rights reserved.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=25743921

47. **Teaching beyond retirement: the consultant neuroradiologist**. A O'Dowd. BMJ. 2024 Apr 29;385:q796. DOI: 10.1136/bmj.q796

    Consultant neuroradiologist Ian Turnbull, despite retiring in 2008, remained committed to teaching and mentoring future doctors. With a career spanning North Manchester General Hospital and Salford Royal Hospital, he continued teaching at Betsi Cadwaladr University Health Board and from home for 11 years post-retirement. Turnbull's passion for radiology and dedication to training earned him the Royal College of Radiologists' Trainer Award in 2011. He emphasizes communication, empathy, and courtesy as essential skills for doctors, encouraging trainees to simplify complex information and treat patients and colleagues respectfully. For Turnbull, a solid foundation in training is key to building a competent medical career. His advice to young doctors: stay open-minded about medicine.

48. **Transitions to retirement: challenges and strategies**. GA Taylor, A Brody, BD Coley, M Dempsey, M DiPietro, M Hernanz-Schulman, RS Ayyala. Pediatric Radiology. 2024 Jun;54(7):1206-1211. DOI: https://doi.org/10.1007/s00247-024-05889-6

    Change is inevitable, and transitions are a normal part of life, both personal and professional. The transition to retirement can be challenging and raise anxieties about the loss of financial stability, personal identity, and meaningful purpose [1]. While much effort has been devoted to the development and mentoring of physicians in early and mid-career, little attention has been paid to older physicians in late career [2, 3]. Many physicians find themselves "too busy" to think about or plan for retirement. Yet, the American College of Radiology recommends that preplanning for retirement begin at least 10 years before a physician retires [4]. In addition, there is evidence that women and minority physicians may experience different challenges in achieving successful retirement [5]. This article combines a brief review of research on late-career physicians with individual stories of pathways taken along with challenges and concerns encountered along the way.

49. **The Aging Surgeon: Considerations for Navigating a Successful and Satisfying Career**. BR Smith, EH Phillips, JA Freischlag, K Inaba, M Stamos. Am Surg. 2024 Oct;90(10):2351-2356. DOI: 10.1177/00031348241256076

    Our careers as surgeons are some of the busiest and perhaps most sought after in existence. We have all put in countless years of tenacious effort, at times blood, frequent sweat, and occasional tears, to have the privilege to care for others and correct their ailments. Many of us are like freight trains rolling down the tracks indefinitely. But all too often we finish our training and head down those tracks without considering what stops we should make along the way, which forks in the tracks we should consider taking, and perhaps most often, we do not consider how we are going to eventually stop the train. Most of us have been witness to colleagues who keep working beyond their prime, be it for lack of alternative opportunities, lack of hobbies to retire to, or for lack of insight into their own decline. From these observations was born this presidential panel. As you can see, it is a collection of past presidents of So Cal ACS, with the exception for Dr. Freischlag (who we all know would have served as president at some point had she never relocated away from Southern California). Each of these speakers has unique experience from their own careers that they will share with us so we can take pause and consider their insights and wisdom for how to navigate a successful and satisfying career.

50. **The Aging Surgeon: Implications for the Workforce, the Surgeon, and the Patient**. PJ Schenarts and S Cemaj. The Surgical clinics of North America. 2016;96(1):129-138. https://dx.doi.org/10.1016/j.suc.2015.09.009

    Surgeons suffer from the same physiologic impairments common to all people with advancing age. These impairments not only affect the surgeon but also the patients under their care. This article delineates the epidemiologic context of the graying population of surgeons and the cognitive and physiologic changes that occur as the result of aging, the consequence of which is that greater experience does not necessarily equate with better clinical outcomes. This work also addresses potential methods for the ongoing evaluation of the aging surgeon and how elder surgeons may be best used as they reach the conclusion of their career.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26612025

51. **The Aging Surgeon: Planning for Retirement Across All Stages of One's Surgical Career**. EM Carlisle, BA Shakhsheer, KW Gow, CE Bagwell. J Pediatr Surg. 2024 May;59(5):763-767. DOI: 10.1016/j.jpedsurg.2024.01.027

    Most surgeons view their work as their persona: “what and who I am.” What could be more rewarding, or more challenging, than a career in surgery? It is no surprise that many surgeons are reluctant to “walk away” from the satisfaction, the comradery, and the respect accumulated over many years in practice. Over half of the surgeons in practice today in the US are older than 55 [1] (one in seven beyond 70 years) [2]. Furthermore, the number of aging physicians and surgeons is increasing over time, having quadrupled over the past 40 years [3]. Given the projected shortage in surgical workforce in future years and concern for decline of cognitive function and psychomotor

performance with age [4], the question of how and when a given surgeon should consider retirement is relevant and significant to the individual surgeon and the community overall [4]. We suggest that one should consider and plan for when to leave practice at each stage of their surgical career: Early, Middle, and Late, to promote a more intentional transition to retirement that balances the needs of the individual surgeon with other external factors, including the needs of the community. In this paper, we explore the key issues surgeons face during the Early, Middle, and Late stages of a surgical career and suggest how one may plan for eventual retirement during each of these stages.

52. **Am I Too Old To Do This Anymore?**. F Nahai. Aesthetic surgery journal. 2016;36(5):626-628. https://dx.doi.org/10.1093/asj/sjw041

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26931308

53. **Assessing performance in ageing surgeons: systematic review**. S Bhat, B Chia, W Babidge, GJ Maddern. British Journal of Surgery. 2023 Oct 10;110(11):1425-1427. https://doi.org/10.1093/bjs/znad158.

    https://pubmed.ncbi.nlm.nih.gov/37260108/

54. **Career reflections of retired surgeons**. L Hewitt and B Ashford. ANZ journal of surgery. 2023;93(1-2):21-3. https://dx.doi.org/10.1111/ans.18173

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med23&NEWS=N&AN=36420700

55. **A Consensus Study: Generational Differences in Neurosurgeons' Perception of Retirement and Practice Limits.** M Rajagopal, J Boyle, V Patel, C Opalak, DJ Rivet and J Reavey-Cantwell. World neurosurgery. 2021;155:e716-e726. https://dx.doi.org/10.1016/j.wneu.2021.08.129

    BACKGROUND: Concerns about the changing demographics in the United States and the aging of the neurosurgical workforce exist. Both the importance and inherent risk of surgical responsibilities suggest that thought be given to whether workloads should change later in surgeons' careers. We sought to assess current neurosurgeons' expectations concerning their late-stage careers.

    METHODS: A survey was sent to 3317 U.S. board-certified neurosurgeons. It was designed to assess surgeons' perceptions of call and operative responsibilities in the later stages of their careers. Statistical analyses were completed in R version 3.6.1, with an alpha set to 0.05.

    RESULTS: Six-hundred and fifty-nine neurosurgeons completed the questionnaire. Seventy-seven percent believed that the call burden should decrease later in practice, and 66% planned to decrease their own call burden later in their career. The most common age range for planned retirement was 65 to 69 years (36%), followed by 70+ years (33%). Most (67%) believed that there should not be a mandatory age to stop operating. More recent year of residency completion was negatively associated with the belief that call burden should decrease at older age groups and positively associated with support for a mandatory age to stop operating as well as an earlier retirement age.

CONCLUSIONS: This study suggests that neurosurgeons have differing views on how workloads should change later in their careers. Younger neurosurgeons support an earlier decrease in workload or even a policy-mandated stop to operating after a certain age. These results may give insight into future trends and turnover in neurosurgery and provide a valuable tool to help practices anticipate workforce changes.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med20&NEWS=N&AN=34500095

56. **A Day at the Office: Smooth Transitions-Setting Up the Next Phase of a Professional Life**. DW Lundy. Clinical orthopaedics and related research. 2017;475(8):1966-1968. https://dx.doi.org/10.1007/s11999-017-5269-x

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28155211

57. **Discussion: Making the End as Good as the Beginning: Financial Planning and Retirement for Women Plastic Surgeons**. AK Silva and DH Song. Plastic and reconstructive surgery. 2016;138(4):941-942. https://dx.doi.org/10.1097/PRS.0000000000002557

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=27673524

58. **Examining the Surgical Life**. TG Hughes and J Elsey. The American Surgeon. 2021;87(3):333-335. https://dx.doi.org/10.1177/0003134821998667

    Debriefing after a major event is a key component in ongoing improvement in performance. Likewise, reflecting on one's career at the time of leaving the operating room environment is an opportunity to transmit the lessons learned from decades of surgical practice. The authors, recently retired from daily operating and leaders in American surgery, reflect on the impact of surgical life on surgeons and their personal lives. Observations regarding selection of medical students, surgical trainees and practice models are presented from this perspective.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med19&NEWS=N&AN=33625869

59. **The Exit Strategy: Preparing for Retirement.** W. A. Baumgartner. Thoracic surgery clinics. 2024;34(1):105-110. https://dx.doi.org/10.1016/j.thorsurg.2023.08.008

    Retiring from any occupation is difficult, especially one that you love. The majority of cardiothoracic surgeons love what they do every day. It has been said that if you choose a job you love, you never have to work another day in your life. Once a date is determined, preparation, particularly financial, is paramount for a successful outcome. Thoughtful decisions need to be made regarding health benefits and retirement plans [401(k)/403(b)]. Transitions to retirement programs have been instituted in several schools of medicine. Establishing an academy for retired faculty can be an enriching experience for the members and a resource for the institution.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med24&NEWS=N&AN=37953047

60. **Factors affecting retirement and workforce attrition in neurosurgery: results of a Council of State Neurosurgical Societies national survey**. AM Sharma, S Tenny, GL Yang, J Cheng, JK Ratliff, MP Steinmetz, S Krishnamurthy, O Adogwa, and K Swartz. Journal of Neurosurgery. 2024;140(3):839-848. https://dx.doi.org/10.3171/2023.7.JNS231117

    OBJECTIVE: By 2030, the US will not have enough neurosurgeons to meet the clinical needs of its citizens. Replacement of neurosurgeons due to attrition can take more than a decade, given the time-intensive training process. To identify potential workforce retention targets, the authors sought to identify factors that might impact neurosurgeons' retirement considerations.

    METHODS: The Council of State Neurosurgical Societies surveyed practicing AANS-registered neurosurgeons via email link to an online form with 25 factors that were ranked using a Likert scale of importance regarding retirement from the field (ranging from 1 for not important to 3 for very important). All participants were asked: "If you could afford it, would you retire today?"

    RESULTS: A total of 447 of 3200 neurosurgeons (14%) responded; 6% had been in practice for less than 5 years, 19% for 6-15 years, 57% for 16-30 years, and 18% for more than 30 years. Practice types included academic (18%), hospital employed (31%), independent with academic appointment (9%), and full independent practice (39%). The most common practice size was between 2 and 5 physicians (46%), with groups of 10 or more being the next most common (20%). Career satisfaction, income, and the needs of patients were rated as the most important factors keeping neurosurgeons in the workforce. Increasing regulatory burden, decreasing clinical autonomy, and the burden of insurance companies were the highest rated for factors important in considering retirement. Subgroup analysis by career stage, practice size, practice type, and geographic region revealed no significant difference in responses. When considering if they would retire now, 45% of respondents answered "yes." Subgroup analysis revealed that midcareer neurosurgeons (16-25 years in practice) were more likely to respond "yes" than those just entering their careers or in practice for more than 25 years ($p = 0.03$). This effect was confirmed in multivariate logistic regression ($p = 0.04$). These surgeons found professional satisfaction ($p = 0.001$), recertification requirements ($p < 0.001$), and maintaining high levels of income ($p = 0.008$) important to maintaining employment within the neurosurgical workforce.

    CONCLUSIONS: This study demonstrates that midcareer neurosurgeons may benefit from targeted retention efforts. This effort should focus on maximizing professional satisfaction and financial independence, while decreasing the regulatory burden associated with certification and insurance authorization. End-of-career surgeons should be surveyed to determine factors contributing to resilience and persistence within the neurosurgical workforce.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=mesx&NEWS=N&AN=37657112

61. **How and When to Transition to the Next Phase: Reflections.** V. T. Tolo and S. L. Weinstein. Journal of pediatric orthopedics. 2022;42(Suppl 1):S60-S61. https://dx.doi.org/10.1097/BPO.0000000000002043

    With Americans living longer, many physicians and surgeons have extended their medical and surgical practice life beyond the traditional 65-year-old retirement age. As retirement is inevitable, planning for that eventuality, which in early practice years appears unnecessary, is in fact an

exercise which will pay dividends at the time of retirement. Two senior orthopaedic surgeons provide insight on the 2 main issues concerning retirement: how to prepare for retirement while in active practice, and factors to consider as to the timing of that major life event. Copyright © 2022 Wolters Kluwer Health, Inc. All rights reserved.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=35405707

62. **How do trauma surgeons retire with grace?**. R Buckley. Injury. 2023;54(10):110999. https://dx.doi.org/10.1016/j.injury.2023.110999

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med24&NEWS=N&AN=37580214

63. **Insights From Senior Surgeons.** K Templeton and A Walling. JAMA surgery. 2020;155(9):900-901. https://dx.doi.org/10.1001/jamasurg.2020.1680

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med18&NEWS=N&AN=32579201

64. **Insights from Senior Surgeons-Reply.** A Stolarski, E Whang and G Kristo. JAMA surgery. 2020;155(9):901-902. https://dx.doi.org/10.1001/jamasurg.2020.1686

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med18&NEWS=N&AN=32579165

65. **Making the End as Good as the Beginning: Financial Planning and Retirement for Women Plastic Surgeons**. DJ Johnson, D Shenaq and M Thakor. Plastic and reconstructive surgery. 2016;138(4):935-940. https://dx.doi.org/10.1097/PRS.0000000000002556

    Financial planning is critically important to ensure financial security both during a plastic surgical career and in retirement. Unfortunately, plastic surgery training includes very little in the way of financial planning. The information that is available in the literature is mostly geared toward men. Women, with longer lifespans and more family care responsibilities, have unique needs when it comes to financial planning. Adequate attention must also be paid to life after retirement. A plastic surgical career can be all-encompassing, and thus women need to carefully plan volunteer activities, new hobbies, and even a second career to make their retirement years fulfilling and enjoyable. Key points regarding financial planning during the various phases of a woman plastic surgeon's career are discussed. Options for retirement are presented.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=27673523

66. **Managing Career Transitions in Cardiothoracic Surgery**. DS Hui, JA Espinosa, AJ Carpenter. Thorac Surg Clin. 2024 Aug;34(3):291-297. DOI: 10.1016/j.thorsurg.2024.04.012.

    Transitions during a career in cardiothoracic surgery include transition to practice following residency, multiple transitions over the course of the career, and transition to retirement. Each carries some degree of uncertainty and stress, and early preparation for each transition is key to success. A clear understanding of both professional and personal goals drives decisions and choices along the course of a career. It is crucial to seek legal counsel with expertise in physician

employment contracts. Developing collegial and collaborative relationships should be a focus throughout one's career. This article outlines the key elements to successful career progression.

67. **One Man in His Time Plays Many Parts: Transplant Surgeons' Approach to Evolution of Career Identity**. Chumdermpadetsuk R., Montalvan A., Canizares S., Hsiao L., Sullivan A., Rivera B., Eckhoff D., Lee D. American Journal of Transplantation. Conference: ASTS 2025 Winter Symposium. Phoenix United States. 25(1 Supplement 1) (pp S75-S76), 2025. Date of Publication: 01 Jan 2025. https://dx.doi.org/10.1016/j.ajt.2024.12.147.

    Abstract:
    Introduction: The surgical workforce is aging, yet there remains sparse literature on retirement with few qualitative studies of surgeons' perspectives on this important transition. An important area which has not been adequately explored is how surgeons approach the transformation of their physical capabilities over time and the impact of these changes on their career identity.

    Method(s): Following IRB approval and COREQ guidelines, we conducted 60-minute semi-structured interviews with 24 current and 6 retired transplant surgery division chiefs to explore their perceptions of retirement. Thematic analysis using the framework approach was performed to identify key themes.

    Result(s): The cohort was predominantly male (80%), White (77%), and liver transplant surgeons (57%), with an average of 25 years in practice (range 12-40 years). Most participants described chronic pain and development of physical limitations over decades of performing strenuous operations. Liver transplantation was highlighted as particularly strenuous, with frequent comparisons to athletics. While some framed deteriorating health solely as a hindrance to clinical performance, others focused on the surgeon's well-being as an end unto itself and endorsed retiring early enough to experience retirement while in good health. Participants with this view were likely to have greater optimism about retirement. In recognition of the physical demands and limited longevity of operative work, many participants emphasized the importance of developing a well-rounded professional portfolio. Some viewed other aspects of their career, such as hospital administration, education, research, industry involvement, and participation in professional societies, as equally integral to their identity as a surgeon. Cultivating these additional areas of expertise was an active process, with many pursuing further education (such as a Masters degree) or seeking mentors in other disciplines. They believed this approach allowed for greater career longevity with gradual reduction in clinical duties over time, and continued contribution to the field beyond reaching age-related physical limitations.

    Conclusion(s): A holistic approach to well-being, coupled with a multifaceted view of the surgical profession, allows for the evolution of career goals and priorities over time, ultimately enabling graceful transitions into retirement. [Formula presented]

68. **On Patient Safety: When Are We Too Old to Operate?.** M J Lee. Clinical orthopaedics and related research. 2016;474(4):895-898. https://dx.doi.org/10.1007/s11999-016-4722-6

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26818596

69. **Passing the Scalpel: Lessons on retirement planning from retired academic surgeons**. R Anteby, R D Sinyard, MG Healy, AL Warshaw, R Hodin, EC Ellison, R Phitayakorn. American Journal of Surg. 2022 Jul;224(1 Pt A):166-171.

70. **Physicians and Retirement**. RT Sataloff. Ear, Nose, & Throat Journal. 2019;98(7):394-395. https://dx.doi.org/10.1177/0145561319858882

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=31405306

71. **Planning for Retiring From Operating: "Will You Still Need Me, Will You Still Feed Me, When I'm Sixty-Four?"**. JA Freischlag. JAMA surgery. 2019;154(7):653-654. https://dx.doi.org/10.1001/jamasurg.2019.1160

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=31090879

72. **Preparing for retirement: reflections on mistakes made and lessons learned**. DL Larson. Aesthetic surgery journal. 2015;35(2):225-227. https://dx.doi.org/10.1093/asj/sju042

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=25717122

73. **Qualitative Exploration of Abdominal Transplant Surgeon Perception of Retirement**. R Chumdermpadetsuk, A Montalvan, S Canizares, L Hsiao, A Sullivan, B Rivera, D Eckhoff, D Lee. Journal of the American College of Surgeons. October 30, 2024. DOI: 10.1097/XCS.0000000000001237.

    BACKGROUND: For many surgeons, retirement is an emotionally evocative subject, tied to a sense of loss. With minimal guidelines to facilitate a smooth transition, physicians tend to be inadequately prepared. There are few qualitative studies exploring surgeons' perspectives and none focused on transplant surgeons, a population with arguably unique challenges. We set out to define an "ideal" retirement for transplant surgeons, and identify behavioral and cognitive patterns associated with optimism towards retirement.

    STUDY DESIGN: We conducted 60-minute semi-structured interviews with 30 division chiefs of transplant surgery to explore their perceptions of retirement. Thematic analysis using a framework approach was performed to identify key themes.

    RESULTS: The cohort was predominantly male (80.0%) and White (76.7%), with 24.8 years in practice on average (range 12-40 years). Participants expressed desires to retire at the peak of their career trajectory and maintain autonomy in this transition. However, when naming signs of impending retirement, they often cited indicators of burnout. Attributes separating those who were optimistic from others included 1) well-rounded sense of identity, 2) holistic attitude towards one's health and well-being, 3) belief in the ability to exert autonomy over retirement process through long-range planning, 4) community centered mindset, and 5) multifaceted and evolving view of career identity.

    CONCLUSION: While surgeons aspire to "go out on top," many envision working until they can no longer endure it. This discrepancy highlights the need for normalizing discussions around

retirement. With their unique insights, we have the opportunity to develop supportive interventions, such that transplant surgeons retire in a manner which preserves dignity and celebrates their legacy.

74. **Retired Surgeons' Reflections on Their Careers**. A Stolarski, J M Moseley, P O'Neal, E Whang and G Kristo. JAMA Surgery. 2020;155(4):359-361. https://dx.doi.org/10.1001/jamasurg.2019.5476

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med17&NEWS=N&AN=31968054

75. **Retirement plans and perspectives among general surgeons: a qualitative assessment**. L Gotlib Conn and F C Wright. Canadian Journal of Surgery. Journal canadien de chirurgie. 2018;61(5):319-325. https://dx.doi.org/10.1503/cjs.011217

    BACKGROUND: General surgeons' retirement plans have wide-ranging personal, professional and system-level effects. We explored the drivers of and barriers to surgeon retirement to identify opportunities to support career-long retirement planning.

    METHODS: We conducted a qualitative study from May to October 2016 using semi-structured telephone interviews (mean duration 29 min) with general surgeons in Ontario. We used a purposive sampling strategy to recruit surgeons at 3 career stages (no plans to retire within next 5 years, had slowed down practice or planned to slowdown within 5 years, and no longer operating as primary surgeon). We analyzed the data using established techniques of thematic analysis.

    RESULTS: We interviewed 22 general surgeons. Their retirement status ranged from fully retired to no plans to retire. Preservation of reputation and quality care, commitment and succession planning, and retirement planning were dominant themes. Mid-career and senior surgeons' plans were made later in their careers and were driven by desires to preserve reputations and surgical identity. Younger surgeons' (<= 50 yr) early retirement was driven by lifestyle choices and work environment. Logistical barriers and financial insecurity led to retirement delay.

    CONCLUSION: Surgeons begin to plan for retirement both early and late in their careers. Most surgeons wish to establish retirement plans that allow for the gradual reduction of surgical patient care and the creation of job opportunities for younger colleagues balanced by a continued contribution to the profession. Opportunities to support surgeons at all career stages in their retirement planning require further exploration.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=30246991

76. **Should neurosurgeons retire?.** K Ganapathy. Neurology India. 2019;67(2):370-374. https://dx.doi.org/10.4103/0028-3886.258036

    Being a neurosurgeon is a protracted, time-consuming, and labor-intensive occupation. It presupposes excellent, continuing physical and mental competence, and a passion to always do better than the best. During the last two decades, the exponential deployment of operative technology has resulted in a radical transformation, making a neurosurgeon trained four decades ago, run the risk of being outdated. Expectations from patients have reached an all time high level. Socioeconomic and medicolegal aspects cannot be brushed aside. It is universally accepted that in

spite of increasing longevity in the educated upper middle class, the process of ageing per se continues relentlessly. When is enough enough? Is there a risk that a "senior, experienced" neurosurgeon may even become a liability to his patients some day? Should there be a mandatory time point at which a neurosurgeon should necessarily stop operating. The author reviews the published literature and opines that after the age of 65 years, all seniors should agree to their operating privileges being formally reviewed regularly every 2 years.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=31085838

77. **Statement on the aging surgeon**. Anonymous. Bulletin of the American College of Surgeons. 2016;101(1):42-43.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26891501

78. **Stress among UK consultant urologists and factors influencing when they leave full-time NHS practice**. Journal of Clinical Urology. 18(3) (pp 221-230), 2025. Date of Publication: 01 May 2025. https://dx.doi.org/10.1177/20514158231190949

Abstract:
Objective: The UK medical workforce is in crisis. The number of surgeons in National Health Service (NHS) practice has decreased, partly because newly qualified doctors withdraw from the workforce, and partly because of the early retirement of experienced surgeons. The reasons for urological trainee loss are largely known, but stress factors influencing the retirement of consultants before state pension age (SPA) are not.

Method(s): An online survey of the consultant membership of the British Association of Urological Surgeons was carried out over a 12-week period starting in September 2020. Information was sought regarding stresses at work and home, together with factors affecting retirement decisions. Data analysis was performed if > 90% of questions were complete.

Result(s): Overall, 36.5% of 1374 invitees completed the survey. Workplace-based issues were the main causes of stress: on-call, an unsupportive working environment, complaint handling and poor relations with hospital managers were predominant factors which were exacerbated by punitive taxation. Experienced urologists ameliorated these factors by reducing their contracted activity, increasing part-time working and, ultimately, retiring before SPA.

Conclusion(s): Workplace-based factors are associated with stress reported by consultant urologists. Alleviation of stressor factors, especially those related to on-call activity, should be explored to reduce the erosion of the senior workforce.

79. **The surgeon's dilemma--retirement**. BS Goldman. Pacing and Clinical Electrophysiology. 2005 May;28(5):444-5. https://doi.org/10.1111/j.1540-8159.2005.09204.x

https://onlinelibrary.wiley.com/doi/10.1111/j.1540-8159.2005.09204.x

80. **Timing a Surgeon's Retirement: Balancing Experience with Age-Related Decline**. Posnick J.C., Kaban L.B. Journal of Oral and Maxillofacial Surgery. 83(3) (pp 267-268), 2025. Date of Publication: 01 Mar 2025. https://dx.doi.org/10.1016/j.joms.2024.11.014

81. **Toward late career transitioning: a proposal for academic surgeons.** R Richards, R McLeod, D Latter, S Keshavjee, O Rotstein, M G Fehlings, N Ahmed, A Nathens and J Rutka. Canadian Journal of Surgery. Journal canadien de chirurgie. 2017;60(5):355-358. https://dx.doi.org/10.1503/cjs.007617

    SUMMARY: In the absence of a defined retirement age, academic surgeons need to develop plans for transition as they approach the end of their academic surgical careers. The development of a plan for late career transition represents an opportunity for departments of surgery across Canada to initiate a constructive process in cooperation with the key stakeholders in the hospital or institution. The goal of the process is to develop an individual plan for each faculty member that is agreeable to the academic surgeon; informs the surgical leadership; and allows the late career surgeon, the hospital, the division and the department to make plans for the future. In this commentary, the literature on the science of aging is reviewed as it pertains to surgeons, and guidelines for late career transition planning are shared. It is hoped that these guidelines will be of some value to academic programs and surgeons across the country as late career transition models are developed and adopted.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28742011

82. **Untangling the Reasons Surgeons Choose to Leave Clinical Practice, including Retirement**. D Verran, K Templeton, N Sampron, J Braman and P Miller. Journal of the American College of Surgeons. 2020;231(5):608-609. https://dx.doi.org/10.1016/j.jamcollsurg.2020.07.002

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med18&NEWS=N&AN=32951979

83. **A useful set of guidelines: a response to "Toward late career transitioning: a proposal for academic surgeons"**. M Carrier. Canadian Journal of Surgery. Journal canadien de chirurgie. 2017;60(5):E4-E5. https://dx.doi.org/10.1503/cjs.1760055

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28930042

84. **A useful set of guidelines: a response to "Toward late career transitioning: a proposal for academic surgeons": Author response**. J Rutka. Canadian journal of surgery. Journal canadien de chirurgie. 2017;60(5):E5. https://dx.doi.org/10.1503/cjs.1760056

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28930043

85. **A Well-Being Well-Check for Neurosurgery: Evidence-Based Suggestions for Our Specialty Based on a Systematic Review**. S Abdelmageed, VJ Horak, PS Virtanen, SK Lam, KJ Burchiel, JS Raskin. World Neurosurg. 2024 May;185:351-358. DOI: 10.1016/j.wneu.2024.02.093

    BACKGROUND: The path through neurosurgery is rigorous. Many neurosurgeons may experience burnout, depression, or suicide throughout training and practice. We review the literature to help

foster a culture of awareness and selfcare and arm trainees with coping skills to reduce burnout and, thus, suicidality during all phases of their medical careers.

METHODS: A systematic search was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines using 4 databases. 7 studies were included.

RESULTS: Overlying themes of interventions were to increase balance, mindfulness, and physical fitness. The most common interventions included in programs were educational and physical activity. We suggest a comprehensive wellness program emphasizing interventions from 4 wellness dimensions physical, spiritual, mental, and emotional.

CONCLUSIONS: Many neurosurgeons experience burnout, leading to a lack of satisfaction and early retirement; this necessitates a discipline-wide acknowledgment of endemic burnout among neurosurgeons. Systemic changes are needed to refine the training process and prioritize physician wellbeing- this cannot be left to chance.

86. **What constitutes a successful retirement? Invited commentary on: Anteby and coauthors, passing the scalpel: Lessons on retirement planning from retired academic surgeons**. L Flint and C E Scott-Conner. American Journal of surgery. 2022;224(1 Pt A):172-173. https://dx.doi.org/10.1016/j.amjsurg.2022.01.001

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med21&NEWS=N&AN=35000755

87. **What's Important: Retirement, Viewed 2 Years Later**. A J Weiland. The Journal of bone and joint surgery. American volume. 2021;103(19):1861-1862. https://dx.doi.org/10.2106/JBJS.21.00593

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med20&NEWS=N&AN=34255760

88. **What's Important: Staying Connected in Retirement**. M W Chapman. The Journal of Bone and Joint Surgery. American volume. 2019;101(8):755-756. https://dx.doi.org/10.2106/JBJS.19.00074

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=30994594

89. **When a neurosurgeon stops operating**. M Bernstein. Journal of neurosurgery. 2022;138(5):1476-1477. https://dx.doi.org/10.3171/2022.10.JNS222286

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=36334294

90. **When A Surgeon Should Retire?.** I Ahmed. Journal of the College of Physicians and Surgeons--Pakistan : JCPSP. 2016;26(5):424-429. https://dx.doi.org/2328

    The question that when a surgeon should retire has been the subject under discussion since long. In the present era, medical education, knowledge, training, and technology are evolving at a rapid pace. At the other end, age causes decline in physical and cognitive performance. So the older a surgeon is, the more likely that he is remote from his initial education and training in his specialty. Research also proves that the senior surgeons are hesitant to plan for their retirement. So far there is no definitive study matching surgical outcomes to surgeons' age. The author believes that work

done in related domains can provide a better understanding of physician aging and cognition issues, and thus can suggest more effective strategies towards continuous professional development and lifelong learning in medicine.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=27225151

91. **When should surgeons retire?.** N R Bhatt, M Morris, A O'Neil, A Gillis and P F Ridgway. The British journal of surgery. 2016;103(1):35-42. https://dx.doi.org/10.1002/bjs.9925

BACKGROUND: Retirement policies for surgeons differ worldwide. A range of normal human functional abilities decline as part of the ageing process. As life expectancy and their population increases, the performance ability of ageing surgeons is now a growing concern in relation to patient care. The aim was to explore the effects of ageing on surgeons' performance, and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age.

METHODS: A narrative review was performed in MEDLINE using the terms 'ageing' and 'surgeon'. Additional articles were hand-picked. Modified PRISMA guidelines informed the selection of articles for inclusion. Articles were included only if they explored age-related changes in brain biology and the effect of ageing on surgeons' performance., RESULTS: The literature search yielded 1811 articles; of these, 36 articles were included in the final review. Wide variation in ability was observed across ageing individuals (both surgical and lay). Considerable variation in the effects of the surgeon's age on patient mortality and postoperative complications was noted. A lack of neuroimaging research exploring the ageing of surgeons' brains specifically, and lack of real markers available for measuring surgical performance, both hinder further investigation. Standard retirement policies in accordance with age-related surgical ability are lacking in most countries around the world.

CONCLUSION: Competence should be assessed at an individual level, focusing on functional ability over chronological age; this should inform retirement policies for surgeons. Copyright © 2015 BJS Society Ltd Published by John Wiley & Sons Ltd.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26577951

92. **When Surgeons Are "Too Old" to Practice Surgery: Recommendations to Balance the Imperatives of Public Safety and Practical Necessity**. M Cwiek, D J Vick, K Osterhout and V Maher. Hospital Topics. 2023;101(2):119-126. https://dx.doi.org/10.1080/00185868.2021.1977205

Few countries have legally set a maximum age for practicing surgery. This is difficult to sustain as surgeon shortages in many localities require hospitals to grant surgical privileges based on internal peer review systems. This approach is not without problems. Some hospitals and medical societies have developed competency assessment programs. Based on the literature and the experience of various jurisdictions, the authors recommend a policy approach that does not mandate a retirement age for surgeons, but rather a mandatory age of 65 at which surgeons shall be legally subject to periodic assessment of physical dexterity, eye/hand coordination, and cognitive skills.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med23&NEWS=N&AN=34519255

93. **Why Do General Surgeons Decide to Retire?: A Population-level Survey.** H M Poushay, D J Kagedan, J Hallet, L G Conn, K Beyfuss, A Nadler, N Ahmed and F C Wright. Annals of surgery. 2018;267(1):e4-e5. https://dx.doi.org/10.1097/SLA.0000000000002467

Limited recent data exist regarding intended retirement plans for general surgeons (GS). We sought to understand when and why surgeons decide to stop operating as primary surgeon and stop all clinical work. A paper-based survey of practicing GS in the province of Ontario, Canada, was conducted. A questionnaire was developed using a systematic approach of item generation and reduction. Face and content validity were tested. The survey was administered via mail, with a planned reminder. Overall, response rate was 33.5% (242/723). The median age at which respondents planned to/did stop operating was 65 (interquartile range 60-67.5). The median age at which respondents planned to/did retire from all clinical work was 70 (interquartile range 65-72.5). Career satisfaction (97%), sense of identity (90%), and financial need (69%) were factors that influenced the decision to continue operating. Enjoyment of work (79%), camaraderie with surgical colleagues (66%), and financial need (45%) were reasons to continue working after ceasing to operate as the primary surgeon. On multivariate analysis, younger respondents (36-50 years old) perceived they were less likely to continue operating past age 65 (odds ratio 0.13), and academic surgeons were more likely to stop operating after age 65 (odds ratio 2.39). Call coverage by non-staff surgeons was not associated with retirement age. Overall, GS plan to stop operating at age 65, and to cease all clinical activities at age 70. Younger, non-academic surgeons plan to stop operating earlier. Career satisfaction, sense of identity, and financial need are the principal reported motivations to continue operating.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=28817436

94. **With Mirth and Laughter Let Old Wrinkles Come: A Qualitative Exploration of Transplant Surgeons' Perceptions of Retirement**. Chumdermpadetsuk R., Montalvan A., Canizares S., Hsiao L., Sullivan A., Rivera B., Eckhoff D., Lee D. American Journal of Transplantation. Conference: ASTS 2025 Winter Symposium. Phoenix United States. 25(1 Supplement 1) (pp S136), 2025. Date of Publication: 01 Jan 2025. https://dx.doi.org/10.1016/j.ajt.2024.12.266

Abstract:
Introduction: The surgical workforce is aging. The literature indicates academic physicians tend to inadequately prepare for retirement. With few guidelines to facilitate a smooth transition, institutional practices are variable and at times less than ideal. Few qualitative studies explore surgeons' perspectives and none have focused on transplant surgeons, a population with unique challenges. Retirement remains an emotionally fraught subject associated with much uncertainty for many in this community.

Method(s): We conducted 60 minute semi-structured interviews with 30 transplant surgery division chiefs to explore their perceptions of retirement. Thematic analysis was performed using the framework approach to group codes into larger themes. This study was conducted with IRB approval and followed COREQ guidelines.

Result(s): Table 1 displays participant demographic and professional characteristics. Participants universally expressed desires to retire at the peak of their career trajectory and maintain autonomy

in this transition. However, when discussing signs of impending retirement, indicators of burnout were often cited. Participants had different views of their ability to shape their own retirement, which affected their degree of optimism regarding the process. Some felt confident in their ability to detect a subtle decline before clinical significance, while others saw retirement as influenced by external factors beyond their control. Overall, attributes separating those who were optimistic from others were 1) well-rounded sense of identity beyond the professional sphere, 2) holistic attitude towards one's health and well-being, 3) belief in the ability to exert autonomy over retirement process through long range planning, 4) community centered mindset, 5) multifaceted and evolving view of career identity, and 6) broad definition of career success which includes contentment, gratitude, and internal derivation of self-worth.

Conclusion(s): While surgeons aspire to "go out on top," many envision working until they can no longer tolerate it from a physical and/or emotional standpoint. This discrepancy highlights the need to normalize discussions around retirement. With these unique insights, we have the opportunity to design initiatives to help surgeons navigate retirement in a manner which preserves their autonomy and celebrates their legacy. [Formula presented] [Formula presented] DISCLOSURES: R. Chumdermpadetsuk: None. A. Montalvan: None. S. Canizares: None. L. Hsiao: None. A. Sullivan: None. B. Rivera: None. D.E. Eckhoff: None. D.D. Lee: None.

OTHER ARTICLES

COMPETENCY ISSUES

95. **The ageing surgeon: a qualitative study of expert opinions on assuring performance and supporting safe career transitions among older surgeons**. R Sherwood and M Bismark. BMJ quality & safety. 2020;29(2):113-121. https://dx.doi.org/10.1136/bmjqs-2019-009596

    BACKGROUND: Unlike some other safety critical professions, there is no mandatory age of retirement for doctors, including surgeons. Medical regulators in Australia are implementing additional checks on doctors from the age of 70. We describe expert opinions on assuring performance and supporting career transitions among older surgeons.

    METHODS: In this qualitative study, experts in four countries were purposively selected for their expertise in surgical governance. Experts responded to interviews (Australia, New Zealand and UK) or a survey (Canada). A tiered framework of interventions was developed by integrating findings with previous literature and responsive regulation theory.

    RESULTS: 52 experts participated. Participants valued the contribution of senior surgeons, while acknowledging that age-related changes can affect performance. Participants perceived that identity, relationships and finances influence retirement decisions. Experts were divided on the need for age-specific testing, with some favouring whole-of-career approaches to assuring safe care. A lack of validated tools for assessing performance of older surgeons was highlighted. Participants identified three options for addressing performance concerns-remediate, restrict or retire-and emphasised the need for co-ordinated and timely responses.

    CONCLUSION: Experts perceive the need for a staged approach to assessing the performance of older surgeons and tailoring interventions. Most older surgeons are seen to make decisions around career transitions with self-awareness and concern for patient safety. Some older surgeons may benefit from additional guidance and support from employers and professional colleges. A few poorly performing older surgeons, who are recalcitrant or lack insight, require regulatory action to protect patient safety. Developing robust processes to assess performance, remediate deficits and adjust scopes of practice could help to support safe career transitions at any age.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med18&NEWS=N&AN=31363015

96. **Assessing the Performance of Aging Surgeons**. MR Katlic, J Coleman, MM Russell. Journal of the American Medical Association. 2019 Feb 5;321(5):449-450.

    https://jamanetwork.com/journals/jama/article-abstract/2721291

97. **The challenge of competency assessment of the late-career practitioner**. M Steffany. Journal of healthcare risk management: the journal of the American Society for Healthcare Risk Management. 2022;41(3):31-38. https://dx.doi.org/10.1002/jhrm.21492

    Just as the general population of the United States is aging, so, too, is the population of active physicians. Training to become a physician and practice medicine is an arduous process. The

competition to gain admission to medical school is fierce, the price tag of medical education is high, and waiting to learn about matching to a residency program is stressful. No wonder that physicians equate their profession with their identity. This sentiment, along with other factors, has resulted in many physicians continuing to practice well beyond the average retirement age. While each individual ages differently, there is evidence that the aging of physicians and length of time since medical school and residency is associated with deficiencies in history-taking, physical examination, record-keeping, and the ability to problem-solve. For late-career surgeons performing complex surgical procedures, there is a higher mortality rate for patients. Unlike other professions that have a mandatory retirement age, medicine does not. Health systems are grappling with how to fairly assess the competence of late-career practitioners. This article will explore that challenge from different perspectives, identify best practices, and describe how a risk manager can facilitate stakeholder discussion focused on implementing a competency-assessment process that is fair and effective. Copyright © 2021 American Society for Healthcare Risk Management of the American Hospital Association.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med21&NEWS=N&AN=34878708

98. **Clinical assessment of the late-career medical practitioner**. C Wijeratne. Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists. 2016;24(2):140-143. https://dx.doi.org/10.1177/1039856215626649

OBJECTIVES: This paper is a guide to the general psychiatric assessment of the late career medical practitioner (LCP) from a clinical viewpoint., CONCLUSIONS: Late career is a specific developmental stage in medical practitioners, a time of transition towards retirement. The treating psychiatrist should be mindful of the welfare of the practitioner, the public and the profession during the assessment, which is conducted from a complex therapeutic and regulatory viewpoint. It is important to assess the physical, psychological and cognitive health of the LCP. Although rates of burnout, depression and suicidal ideation are lowest in Australian doctors over 60, only a small minority of LCPs over 75 are likely to perform at a cognitive level similar to that of younger colleagues. There are a number of therapeutic challenges, including the practitioner's acceptance of their own ageing. Copyright © The Royal Australian and New Zealand College of Psychiatrists 2016.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26823536

99. **Cognitive Impairment in Aging Physicians: Current Challenges and Possible Solutions**. Devi G, Gitelman DR, Press D, et al. Neurol Clin Pract. 2021 Apr;11(2):167-174.

Abstract
Aging physicians are at a higher risk of cognitive impairment, undermining patient safety and unraveling physicians' careers. Neurologists, occupational health physicians, and psychiatrists will participate in both health system policy decisions and individual patient evaluations. We address cognitive impairment in aging physicians and attendant risks and benefits. If significant cognitive impairment is found after an appropriate evaluation, precautions to confidentially support physicians' practicing safely for as long as possible should be instituted. Understanding that there is heterogeneity and variability in the course of cognitive disorders is crucial to supporting cognitively

impaired, practicing physicians. Physicians who are no longer able to practice clinically have other meaningful options.

100. **Cognitive Screening Tools for Late Career Physicians: A Critical Review**. K D Garrett, W Perry, B Williams, L Korinek and D E J Bazzo. Journal of geriatric psychiatry and neurology. 2021;34(3):171-180. https://dx.doi.org/10.1177/0891988720924712

    Screening measures are widely used in medicine to assess the increased probability that members of a defined population have a particular condition and therefore require more extensive assessment. The rationale for prospective screening of late career physicians (LCPs) is drawn from the following circumstances: Senior physicians-prone to the vicissitudes of aging-comprise nearly a third of the US physician workforce, physicians are poor at self-evaluation, data suggest many have clinically relevant cognitive decline, and screening is an evidence-based, method to detect individuals at risk and determine whether a comprehensive evaluation is necessary. A handful of professional organizations (e.g., surgeons, obstetricians, and a growing number of medical staff credentialing committees) have developed policies in this arena. This focused review compares cognitive screening methods used or recommended for LCPs, with particular attention to the psychometric properties, ease of operational implementation, and appropriate application to physicians-a population selected for high cognitive reserve and skills. Further, we identify gaps in knowledge and practice, including the need for more career-span normative data on physicians' cognitive and work performance. Stakeholders can improve rehabilitation and other supports to LCPs in transition, calling upon the unique expertise of those neuropsychologists who are trained on conducting fitness for duty evaluations, as well as rehabilitation professionals who can assist in developing modifications to practice when indicated or facilitate graceful transitions to retirement when necessary.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med19&NEWS=N&AN=32419575

101. **Ensuring Safe Practice by Late Career Physicians: Institutional Policies and Implementation Experiences**. AA White, TH Gallagher, PH Osinska, DB Kramer, KD Garrett, MM Mello. Ann Intern Med. 2024 Nov 5. DOI: 10.7326/ANNALS-24-00829

    Background: Late career physicians (LCPs; physicians working beyond age 65 to 75 years) may be at higher risk for delivering unsafe care. To oversee LCPs, some health care organizations (HCOs) have adopted LCP policies requiring cognitive, physical, and practice performance screening assessments. Despite recent controversies, little is known about the content and implementation of such policies.

    Objective: To characterize key features of LCP policies and the perspectives of medical leaders responsible for policy development and implementation. Design: Mixed-methods study using content analysis and key informant interviews. Setting: 29 U.S. HCOs with LCP policies active in 2020.

    Participants: 21 purposively sampled interviewees in physician leadership roles at 18 HCOs.

    Measurements: Descriptive statistics of policy features and content analysis of interviews.

Results: Although policies had many commonalities— mandatory universal screening at a trigger age around 70 years, a strategy of screening followed by in-depth assessment of positive results, and commitment to patient safety as the key motive—they varied substantially in the testing required, funding, processes after a positive screening result, and decision making around concerning results. Policies prioritized institutional discretion in interpreting and responding to test results; many lacked clear language about appeals or other procedural protections for physicians. Leaders were generally satisfied with policies but reported preemptive retirements as physicians approached the screening age and cautioned that substantial investment in cultivating physicians' buy-in was required for successful rollout. Limitations: Sampled policies and interviews may not be representative of all HCOs. The analysis excluded the experiences of HCOs that tried and failed to implement LCP screening.

Conclusion: Policies about LCPs are considered successful by institutional leaders. Policy variations and early adopters' implementation experiences highlight opportunities to improve physician acceptance and program rigor.

102. **More than maintaining competence: a qualitative study of how physicians conceptualize and engage lifelong learning.** O'Brien BC, Collins S, Haddock LM, Sani S, Rivera JA. More than Maintaining Competence: A Qualitative Study of How Physicians Conceptualize and Engage in Lifelong Learning. *Perspectives on Medical Education.* 2024; 13(1): 380–391. DOI: https://doi.org/10.5334/pme.1327

PURPOSE: Physicians have a professional responsibility to engage in lifelong learning. Some of this lifelong learning is required to maintain licensure and certification. Yet, this conceptualization captures only a small portion of the content areas and learning processes that physicians need to engage with to ensure quality patient care. Additionally, purposes beyond regulatory requirements and professional obligations likely drive physicians lifelong learning, though these purposes have not been explored. Given the centrality of lifelong learning to quality patient care, our study explores how physicians conceptualize and engage in lifelong learning.

METHOD: We conducted a qualitative interview study using an interpretivist approach. In 2019, we recruited 34 academic physicians from one institution. We analyzed our data to identify themes related to conceptualization of purposes, content areas, and processes of lifelong learning and actual lifelong learning practices.

RESULTS: We interpreted participants' descriptions and examples of lifelong learning as serving three purposes: maintaining competence, supporting personal growth and fulfillment, and engaging in professional stewardship. Much of participants' discussion of lifelong learning centered around keeping up to date with medical knowledge and clinical/procedural skills, though some also mentioned efforts to improve communication, leadership, and teamwork. Participants engaged in lifelong learning through contextual, social, and individual processes.

DISCUSSION: Academic physicians engage in lifelong learning for reasons beyond maintaining competence. Medical knowledge and clinical/procedural skills receive most attention, though other areas are recognized as important. Our findings highlight opportunities for a broader, more comprehensive approach to lifelong learning that spans all areas of medical practice.

103. **Neuropsychological Assessment of the Aging Physician: A Review & Commentary**. Gaudet CE, Del Bene VA. J Geriatr Psychiatry Neurol. 2022 May;35(3):271-279.

Abstract
Late-career physicians (LCPs) are at risk for cognitive changes that may affect their ability to practice medicine. This review aggregates and discusses research that has examined cognitive functioning among physicians, typically when clinically referred for various medical and psychological reasons that may interfere with their ability to practice medicine. Special consideration is devoted to the
role of approaches for examining cognitive functioning (e.g., cognitive screening, cognitive testing, & neuropsychological assessment), normative challenges, and cultural factors that should be considered when evaluating a physician. Based on published studies, there is evidence supportive of the use of cognitive testing and neuropsychological assessment among physicians in a fitness for duty setting. However, prospective studies designed to identify physicians at-risk (i.e., to prevent medical error) are lacking. Additional research is warranted to establish physician-based normative reference groups and aid in test interpretation and prognostication. Moreover, given limitations associated with cognitive testing in isolation, there is a potential role for comprehensive neuropsychological assessment to identify cognitive changes in physicians and provide a supportive pathway to preserve physicians' ability to practice medicine.

104. **Patient safety and the ageing physician: a qualitative study of key stakeholder attitudes and experiences.** A A White, W M Sage, P H Osinska, M J Salgaonkar and T H Gallagher. BMJ quality & safety. 2019;28(6):468-475. https://dx.doi.org/10.1136/bmjqs-2018-008276

BACKGROUND: Unprecedented numbers of physicians are practicing past age 65. Unlike other safety-conscious industries, such as aviation, medicine lacks robust systems to ensure late-career physician (LCP) competence while promoting career longevity.

OBJECTIVE: To describe the attitudes of key stakeholders about the oversight of LCPs and principles that might shape policy development.

DESIGN: Thematic content analysis of interviews and focus groups., PARTICIPANTS: 40 representatives of stakeholder groups including state medical board leaders, institutional chief medical officers, senior physicians (>65 years old), patient advocates (patients or family members in advocacy roles), nurses and junior physicians. Participants represented a balanced sample from all US regions, surgical and non-surgical specialties, and both academic and non-academic institutions.

RESULTS: Stakeholders describe lax professional self-regulation of LCPs and believe this represents an important unsolved challenge. Patient safety and attention to physician well-being emerged as key organising principles for policy development. Stakeholders believe that healthcare institutions rather than state or certifying boards should lead implementation of policies related to LCPs, yet expressed concerns about resistance by physicians and the ability of institutions to address politically complex medical staff challenges. Respondents recommended a coaching and

professional development framework, with environmental changes, to maximise safety and career longevity of physicians as they age.

CONCLUSIONS: Key stakeholders express a desire for wider adoption of LCP standards, but foresee significant culture change and practical challenges ahead. Participants recommended that institutions lead this work, with support from regulatory stakeholders that endorse standards and create frameworks for policy adoption. Copyright © Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=30237318

105. **Should we screen aging physicians for cognitive decline?**. N Shilnikova, F Momoli, MK Taher, J Go, I McDowell, N Cashman, R Terrell, E Iscan Insel, J Beach, N Kain, D Krewski. Aging Ment Health. 2024 Jan-Feb;28(2):207-226. DOI: 10.1080/13607863.2023.2252371

Objectives: To synthesize evidence relevant for informed decisions concerning cognitive testing of older physicians.

Methods: Relevant literature was systematically searched in Medline, EMBASE, PsycInfo, and ERIC, with key findings abstracted and synthesized.

Results: Cognitive abilities of physicians may decline in an age range where they are still practicing. Physician competence and clinical performance may also decline with age. Cognitive scores are lower in physicians referred for assessment because of competency or performance concerns. Many physicians do not accurately self-assess and continue to practice despite declining quality of care; however, perceived cognitive decline, although not an accurate indicator of ability, may accelerate physicians' decision to retire. Physicians are reluctant to report colleagues' cognitive problems. Several issues should be considered in implementing cognitive screening. Most cognitive assessment tools lack normative data for physicians. Scientific evidence linking cognitive test results with physician performance is limited. There is no known level of cognitive decline at which a doctor is no longer fit to practice. Finally, relevant domains of cognitive ability vary across medical specialties.

Conclusion: Physician cognitive decline may impact clinical performance. If cognitive assessment of older physicians is to be implemented, it should consider challenges of cognitive test result interpretation.

106. **Sustaining Lifelong Competency of Surgeons: Multimodality Empowerment Personal and Institutional Strategy**. TK Rosengart, JH Chen, NL Gantt, P Angelos, AL Warshaw, JE Rosen, ND Perrier, KL Kaups, GM Doherty, T Zoumpou, SW Ashley, W Doscher, D Welsh, M Savarise, MJ Sutherland, AN Sidawy, AM Kopelan. J Am Coll Surg. 2024 Apr 9. doi: https://doi.org/10.1097/xcs.0000000000001066.

GENDER ISSUES

107. **Aging women and men in the medical profession: The effect of gender and marital status on successful aging and retirement intent in Australian doctors**. C. Peisah, G. M. Luscombe, J. K. Earl and C. Wijeratne. Journal of women & aging. 2019;31(2):95-107. https://dx.doi.org/10.1080/08952841.2018.1412391

    Despite increasing interest from the medical profession in aging and retirement, we know little about effects of gender, marital status, and cohort on aging within the profession. We surveyed 1,048 Australian doctors from "younger" (55-64) and "older" (65-89) cohorts, investigating gender and marital effects on perceptions of successful aging, career, and retirement intent. Women intend to retire earlier. Younger cohort and married women more frequently viewed their career as a calling, while women in general, and single women more frequently, endorsed personal successful aging more than men. Broader understanding of the different experiences of aging for men and women doctors is needed.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=29220630

108. **Factors Influencing Retirement Decisions of Senior Faculty at U.S. Medical Schools: Are There Gender-Based Differences?** R. B. Levine, A. Walling, A. Chatterjee and K. A. Skarupski. Journal of women's health (2002). 2022;31(7):974-982. https://dx.doi.org/10.1089/jwh.2021.0536

    PURPOSE: Women comprise almost one-third of academic medicine faculty 60 years of age and older. Gender disparities have been documented across many measures in medicine, including salary, promotion rates, and leadership positions and may impact long-term career and retirement decisions. The authors sought to describe gender differences in retirement decisions among late-career, full-time medical school faculty.

    MATERIALS AND METHODS: The authors conducted a secondary analysis of cross-sectional survey data from a 2017 survey of faculty 55 years of age and older at 14 U.S. Medical Schools. Responses were compared for differences by gender using bivariate and multivariable analyses. Results: Among the 2,126 respondents (41% response rate), the majority were male (67%), and the average age was 62. Less than half (45%) had current plans to retire and 50% reported that they would consider working part time. Women faculty were less likely to be professors or on a tenure track and more likely to be single and report past and current caregiving responsibilities. Women differed from men in the personal and professional factors influencing retirement decisions with women more likely to identify health insurance, sense of burnout, lack of access to career advancing resources and opportunities, feeling devalued at work, and caregiving responsibilities as important issues.

    CONCLUSIONS: Women late-career faculty report unique and salient factors influencing retirement plans that may reflect cumulative gender-based career differences and disparities. Institutions should be aware of these differences and work to support women during late career and retirement transitions, including creating opportunities for faculty to remain engaged in meaningful work during retirement transitions if they desire to do so.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=35849754

109. **Issues Faced by Senior Women Physicians: A National Survey.** K. Templeton, K. M. Nilsen and A. Walling. Journal of women's health (2002). 2020;29(7):980-988. https://dx.doi.org/10.1089/jwh.2019.7910

BACKGROUND: As the first large numbers of female physicians complete their careers, information is needed to enable institutions and individuals to optimize the final career phase and transition to retirement of these women, as well as to help younger women physicians prepare for later phases of their careers.

MATERIALS AND METHODS: To identify the leading issues for older female physicians, a 34-item electronic questionnaire covering heath, finances, preparation for and attitudes about retirement, caretaking responsibilities, life-work integration, various aspects of discrimination and harassment, professional isolation, and work-related stress and burnout-incorporating standardized measures of career satisfaction was distributed through the Kansas Medical Society and nationally through the American Medical Association Senior Physicians Section newsletter to female physicians older than 60 years in 2018. A total of 155 physicians self-identified as eligible and completed at least half of the survey.

RESULTS: Respondents were 60-87 years of age, mean 70.4 (+/-6.4) years. The majority reported good health and being financially well prepared for retirement. Twenty percent were caretakers for grandchildren, parents, or spouses. Measures of career and job satisfaction were reasonably high, despite negative work environment and burnout scores. Problems with family/career balance, age- and gender-based discrimination and harassment, salary inequity, and professional isolation persisted throughout their careers, but diminished in frequency for senior women.

CONCLUSIONS: Issues faced by younger women physicians do not disappear with age or seniority. To recruit and support female physicians, issues such as balancing family/work responsibilities, combating harassment and bias, and promoting healthy work environments must be addressed throughout their entire careers.

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GENERAL TOPICS

110. **Adaptation to life after sport for retired athletes: A scoping review of existing reviews and programs**. Voorheis P, Silver M, Consonni J. PLoS One. 2023 Sep 21;18(9):e0291683. doi: 10.1371/journal.pone.0291683.

ABSTRACT: Retirement from elite sport can be highly distressing for athletes, and many report experiencing depression and anxiety in adjusting to this transition. In this article, a discursive psychological approach is employed to explore constructions of choice and identity around elite athletes' retirements within Australian newsprint media. Within these accounts, three 'types' of retirements were identified: retirements occurring in relation to age, injury, or active choice. Retiring with individual agency and at an appropriate time was repeatedly privileged, whereas retiring in different ways was routinely problematized. In privileging particular ways of retiring, certain identity positions were made more accessible than others. Consequently, certain actions and choices are deemed appropriate (or not) for athletes, ultimately constraining decision-making around retirement. The implications of such limited identity positions and choices are explored in relation to the psychological distress and clinical concerns that emerge among many athletes in the transition out of elite sport.

111. **The Aging Physician and the Medical Profession: A Review.** E. P. Dellinger, C. A. Pellegrini and T. H. Gallagher. JAMA surgery. 2017;152(10):967-971. https://dx.doi.org/10.1001/jamasurg.2017.2342

IMPORTANCE: The issue of the aging physician and when to cease practice has been controversial for many years. There are reports of prominent physicians who practiced after becoming dangerous in old age, but the profession has not demonstrated the ability to prevent this. A mandatory retirement age could be discriminatory and take many competent physicians out of practice and risk a physician shortage. An increasing body of evidence regarding the relationship between physicians' age and performance has led organizations, such as the American College of Surgeons, to revisit this challenge.

OBSERVATIONS: Since 1975, the number of practicing physicians older than 65 years in the United States has increased by more than 374%, and in 2015, 23% of practicing physicians were 65 years or older. Research shows that between ages 40 and 75 years, the mean cognitive ability declines by more than 20%, but there is significant variability from one person to another, indicating that while some older physicians are profoundly impaired, others retain their ability and skills. There are age-based requirements for periodic testing and/or retirement for many professions including pilots, judges, air traffic controllers, Federal Bureau of Investigation employees, and firefighters. While there are not similar requirements for physicians, a few hospitals have introduced mandatory age-based evaluations.

CONCLUSIONS: As physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers regarding wellness and competence would be beneficial both to physicians and their patients. While it is unlikely that this will become a national standard soon, individual health care organizations could develop policies similar to those present at a few US institutions. In addition, large professional organizations should identify a range of acceptable policies to address the aging physician while leaving institutions flexibility to

customize the approach. Absent robust professional initiatives in this area, regulators and legislators may impose more draconian measures.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28724142

112. **America Needs to Radically Rethink What It Means to Be Old**. J Rauch. The Atlantic. 2025 January. https://archive.ph/lU1fh

    As 100-year lifespans become more common, the time has come for a new approach to school, work, and retirement.

113. **The challenges of physician retirement.** R. Collier. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2017;189(2):E90-E91. https://dx.doi.org/10.1503/cmaj.109-5356

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=pmnm4&NEWS=N&AN=27956394

114. **Critical reflection on physician retirement.** M. P. Silver. Canadian family physician Medecin de famille canadien. 2016;62(10):783-784.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=27737969

115. **Doctors who retire early often met with scorn.** R. Collier. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2018;190(14):E449-E450. https://dx.doi.org/10.1503/cmaj.109-5564

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=29632045

116. **Elite athletes and retirement: Identity, choice, and agency**. S. Cosh, S. Crabb, & A. LeCouteur. Australian Journal of Psychology. 2013;65(2), 89–97.

117. **Engaging Retired Physicians as Educators: Motivations and Experiences of Participants in a Novel Educational Program.** L. H. Plotnick, R. Sternszus, M. E. Macdonald and Y. Steinert. Academic medicine: journal of the Association of American Medical Colleges. 2022;97(12):1841-1846. https://dx.doi.org/10.1097/ACM.0000000000004981

    PURPOSE: Physician retirement has important impacts on medical learners as well as retiring physicians themselves. Retiring physicians take with them a wealth of knowledge, wisdom, and expertise and can feel a loss of identity, lack of fulfillment, and reduced social connectedness after leaving the institution. To address this, a novel educational program providing retired physicians with renewed educational roles was implemented in 2018 within a university-associated pediatric department. This study sought to explore the retired physicians' experiences in this new intergenerational program, including their motivations to reengage as educators after retirement., METHOD: The authors designed this study using qualitative description. Semi structured interviews were conducted in the Department of Pediatrics of McGill University in 2019 with retired physicians who participated in the educational program's inaugural year. Role theory and psychosocial

development theory were used to design the interview guide and inform the thematic analysis. Iterative analysis of the interview transcripts was deductive and inductive.

RESULTS: Of the 8 retired physicians who participated in the program's first cohort, 7 participated in this study. Analysis of the data yielded 4 main themes: a challenging shift to retirement, a desire for reengagement after retirement, role dissonance, and gaining by giving. The retired physicians were motivated to engage as educators. Although they experienced some discomfort in their new nonclinical roles, they described their experiences as fulfilling, with benefits such as intellectual stimulation, social connectedness, and a sense of purpose.

CONCLUSIONS: Retired physicians' motivations to reengage academically and their experiences contributing to educational activities in this program highlight the importance of supporting physicians during the transition to retirement and establishing formal programs to engage retired physicians as educators.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med22&NEWS=N&AN=36449922

118. **Factors influencing the decisions of senior UK doctors to retire or remain in medicine: national surveys of the UK-trained medical graduates of 1974 and 1977.** F. Smith, S. Lachish, M. J. Goldacre and T. W. Lambert. BMJ open. 2017;7(9):e017650. https://dx.doi.org/10.1136/bmjopen-2017-017650

OBJECTIVE: To report attitudes to retirement of late-career doctors.

DESIGN: Questionnaires sent in 2014 to all UK medical graduates of 1974 and 1977.

SETTING: United Kingdom., PARTICIPANTS: 3695 medical graduates.

MAIN OUTCOME MEASURES: Factors which influenced doctors' decisions to retire and factors which encouraged doctors to remain in work., RESULTS: The response rate was 85% (3695/4369). 55% of respondents overall were still working in medicine (whether they had not retired or had retired and returned; 61% of men, 43% of women). Of the retirees, 67% retired when they had originally planned to, and 28% had changed their retirement plans. Fifty per cent of retired doctors cited 'increased time for leisure/other interests' as a reason; 43% cited 'pressure of work'. Women (21%) were more likely than men (11%) to retire for family reasons. Women (27%) were more likely than men (9%) to retire because of the retirement of their spouse. General practitioners (GPs) were more likely than doctors in other specialties to cite 'pressure of work'. Anaesthetists and GPs were more likely than doctors in other specialties to cite the 'possibility of deteriorating skill/competence'. Radiologists, surgeons, obstetricians and gynaecologists, and anaesthetists were most likely to cite 'not wanting to do out-of-hours work'. Doctors who were still working were asked what would encourage them to stay in medicine for longer. Factors cited most frequently were 'reduced impact of work-related bureaucracy' (cited by 45%) and 'workload reduction/shorter hours' (42%). Men (30%) were more motivated than women (20%) by 'financial incentivization'. Surgeons were most motivated by 'reduction of on-call or emergency commitments'.,

CONCLUSIONS: Retention policy should address ways of optimizing the clinical contribution of senior doctors while offering reduced workloads in the areas of bureaucracy and working hours,

particularly in respect of emergency commitments. Copyright © Article author(s) (or their employer(s) unless otherwise stated in the text of the article) 2017. All rights reserved. No commercial use is permitted unless otherwise expressly granted.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=29089347

119. **A guide for medical practitioners transitioning to an encore career or retirement**. Wijeratne C, Earl J.Med J Aust. 2022 Feb 7;216(2):106. doi: 10.5694/mja2.51378. Epub 2021 Dec 25.

120. **Healthcare professionals' retirement intentions: The roles of financial and work factors.** Y. Shobo and J. D. Wong. Journal of Financial Therapy. 2019;10(1). https://dx.doi.org/10.4148/1944-9771.1160

    Delayed retirement has been utilized to provide a short-term solution to the healthcare workforce demand-supply gap arising from increased retirement and healthcare needs by the aging population. To adequately design an effective financial therapy and retirement delaying program, a knowledge of key factors affecting retirement intentions is critical. This study examines the influences of financial and work-related factors on retirement intentions among a sample of 21,860 healthcare professionals between 50 to 65 years old. Using data from the Virginia's 2016 Dentist, Licensed Practical Nurse, Registered Nurse, Physician, and Pharmacist Surveys, multinomial logistic regressions were conducted to identify key factors associated with retirement intentions. Study findings show that having lower income, education debt, and higher job satisfaction, among other factors, were associated with delayed retirement intentions. Incorporating this finding will be key in the creation of successful retirement delaying programs, and ultimately in the reduction of the healthcare workforce demand-supply gap. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc18&NEWS=N&AN=2019-58361-001

121. **Influence of electronic medical record implementation on provider retirement at a major academic medical centre.** M. G. Crowson, C. Vail and R. J. Eapen. Journal of evaluation in clinical practice. 2016;22(2):222-226. https://dx.doi.org/10.1111/jep.12458

    RATIONALE, AIMS AND OBJECTIVES: The push for electronic medical record (EMR) implementation is grounded on increasing efficiency and cost savings. Our objective was to investigate the effect of EMR implementation on provider attrition.

    METHODS: We completed a retrospective study investigating whether medical provider attrition, clinical MD or equivalent, coincided with EMR implementation. We analysed monthly provider attrition rates and mean age at attrition 24 months preceding the EMR 'go-live' date at our institution and 12 months after.

    RESULTS: 208 provider departures occurred between July 2011 and June 2014. The attrition categories were classified as 'departure' (n = 137, 65.9%), 'emeritus' (n = 30; 14.4%), 'no specified reason' (n = 26; 12.5%) and 'not reappointed' (n = 15; 7.2). The most common degree held by departing providers was 'MD' (n = 170; 81.7%). Most departures occurred in June 2013 (n = 24).

The mean provider age at departure was 46.4 years +/- 2.9 years for June 2012, 48.1 years +/- 2.5 years for June 2013 and 45.0 years +/- 4.1 years for June 2014. Our data indicate a trend for both an increase in number of departing providers, as well as an increased mean age in the month immediately prior to EMR implementation.

CONCLUSION: To date, no other investigation of the effect of EMR implementation of provider retirements have been published. We demonstrate a peak in provider attrition in the month prior to EMR implementation that may not be explained by normal attrition patterns with an academic calendar.

LEVEL OF EVIDENCE: Level 5 - qualitative or descriptive study. Copyright © 2015 John Wiley & Sons, Ltd.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26395432

122. **Legal Issues and the Aging Physician.** J. F. Chase-Lubitz. Rhode Island medical journal (2013). 2017;100(9):23-25.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28873480

123. **Motivation to work and attitudes towards retirement among physicians**. FU Jung, E Bodendieck, M Luppa, SG Riedel-Heller. BMC Health Serv Res. 2024 Jul 25;24(1):846. DOI: https://doi.org/10.1186/s12913-024-11296-2

Background: The healthcare system is currently in a state of tension due to a shortage of physicians, the early retirement of health care professionals and an increasing need for care within an (aging) society. Therefore, the aim of the present study was to examine physicians' attitudes towards retirement and possible influencing factors on their motivation to work.

Method: Data were collected as part of a baseline survey of a long-term study. The sample includes a variety of physicians (n = 625), working in outpatient or inpatient care, who have not yet reached the retirement age of 67. The primary outcome was to survey attitudes towards retirement using the Motivation to Work scale. Work-related characteristics (e.g., with regard to contract or working hour) as well as job satisfaction, overall health, and burnout were also included in the analyses (correlations and linear regression models).

Results: According to the results, sociodemographic characteristics are not significantly related to motivation to work, whereas the other parameters (satisfaction, health, and burnout) influence attitudes towards retirement significantly.

Conclusions: The results underline the need to improve the occupational conditions of physicians across different medical settings. More research is needed to understand physicians' decision-making with regard to retirement, especially in terms of work-related characteristics and differences.

124. **Moving Forward: Retirement Opportunities for Senior Physicians.** D. Singer. Rhode Island medical journal (2013). 2017;100(9):26-28.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=28873481

125. **Occupational Determinants of Successful Aging in Older Physicians.** C. Wijeratne, C. Peisah, J. Earl and G. Luscombe. The American journal of geriatric psychiatry: official journal of the American Association for Geriatric Psychiatry. 2018;26(2):200-208. https://dx.doi.org/10.1016/j.jagp.2017.07.008

OBJECTIVES: Demographic, physical and psychological associations of successful aging (SA) have been evaluated, but occupational factors have not. Nor has SA been evaluated in a specific occupational group. The aims of this study were to examine the occupational associations of SA in older physicians, and to explore the concept of occupational SA.

METHODS: Physicians aged 55+ years completed self-ratings of occupational and personal SA on a 10-point visual analogue scale (VAS; 1 being "least successful" and 10 "most successful"). Associations between occupational and personal SA (defined as 8-10 on the VAS), respectively, and demographic and practice characteristics; health; social and financial resources; cognitive, emotional and motivational resources; work centrality; and anxiety about aging were examined.

RESULTS: Rates of occupational SA (69.2%; 95% CI: 66.3-72.0) were significantly higher than personal SA (63.1%; 95% CI: 60.1-66.0) in the sample of 1,048 physicians. Occupational and personal SA were strongly positively correlated ($r = 0.73$, $N = 1,041$, $p < 0.001$). Personal SA was predicted by demographic (older age, female, international medical graduate, urban practice), physical (better self-rated health), psychological (less depression, better cognitive, emotional and motivational resources, and greater anxiety about aging), and occupational (higher work centrality, fewer practice adaptations and not intending to retire) factors.

CONCLUSIONS: Occupational factors are central to physicians' self-conceptualization of SA. That greater work centrality, fewer work adaptations and less retirement planning were associated with personal SA suggests older physicians' sense of "success" is intertwined with continuing practice. There is a need for educating physicians to adapt to aging and retirement.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=29239799

126. **Older Physicians' Reporting of Psychological Distress, Alcohol Use, Burnout and Workplace Stressors.** Wijeratne C, Johnco C, Draper B, Earl JK.Am J Geriatr Psychiatry. 2021 May;29(5):478-487. doi: 10.1016/j.jagp.2020.09.010. Epub 2020 Sep 12.

OBJECTIVE: Most of the published data on the psychological health of physicians has focused on the youngest members of the profession. The aims of this analysis were to determine how psychological morbidity changes across the career cycle.

METHODS: We report data from the cross-sectional National Mental Health Survey of Doctors and Medical Students, conducted in Australia. Age differences in psychological distress, suicidal ideation, alcohol use, burnout, workplace, and personal stressors were examined for younger (40 years and younger), middle aged (41-60), and older (61+) physicians.

RESULTS: A total of 10,038 physicians responded. Older physicians reported significantly less psychological distress, burnout and suicidal ideation than younger and middle aged colleagues, findings that were maintained after adjusting for sex and excluding trainees. There were no group differences in overall alcohol use and high risk drinking. On multivariate analysis, the largest contributor to psychological distress in older physicians was a past history of mental disorder. There was a decline across age groups in the endorsement as "very stressful" of work-life conflict and work-anxiety stressors such as fear of making mistakes. Older physicians were least likely to feel very stressed by all workplace stressors.

CONCLUSION: The better psychological health of older physicians highlights the need to consider physician health according to age and career stage. Apart from the decline in work stressors, in particular work-life conflict, there may be a survivor effect such that physicians who practice into older age have developed greater resilience and professional maturation.

127. **Patterns of physician retirement and pre-retirement activity: a population-based cohort study.** L. Hedden, M. R. Lavergne, K. M. McGrail, M. R. Law, L. Cheng, M. A. Ahuja and M. L. Barer. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2017;189(49):E1517-E1523. https://dx.doi.org/10.1503/cmaj.170231

BACKGROUND: Knowing when physicians retire and how they practise in the pre-retirement years is important information for health human resource planning. We identified patterns of retirement for physicians in British Columbia and the determinants of when and how physicians retire.

METHODS: For this population-based retrospective cohort study, we used administrative data to examine activity levels and to identify retirements among BC's practising physicians. We included all physicians who were at least 50 years of age as of March 2006 and who had received payments for clinical services in at least 1 year between 2005/06 and 2011/12. We defined retirement as a permanent drop in monthly payments to less than $1667/month ($20 000/yr). We examined the patterns and timing of retirement by age, sex, specialty and location using linear and logistic regression models.

RESULTS: Of the 4572 physicians who met the inclusion criteria, 1717 (37.6%) retired during the study period. The average age at retirement was 65.1 (standard deviation 7.8) years. Controlling for other demographic and practice characteristics, we found that women and physicians working in rural areas retired earlier, by 4.1 (95% confidence interval [CI] -4.9 to -3.2) years and 2.3 (95% CI -3.4 to -1.1) years, respectively. We found no difference in retirement age by specialty. We identified 4 patterns of pre-retirement activity: slow decline, rapid decline, maintenance and increasing activity. About 40% of physicians (440/1107) reduced their activity levels by at least 10% in the 3 years preceding retirement.

INTERPRETATION: During the study period, physicians in BC - particularly women and those in rural areas - retired earlier than indicated by licensure and survey data. Many physicians reduced their practice activity in the pre-retirement years. These trends indicate that forecasts relying on licensure "head counts" are likely overestimating current and future physician supply.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=29229713

128. **Physical activity and healthy ageing: A systematic review and meta-analysis of longitudinal cohort studies**.

Daskalopoulou C, Stubbs B, Kralj C, Koukounari A, Prince M, Prina AM. Physical activity and healthy ageing: A systematic review and meta-analysis of longitudinal cohort studies. Ageing Res Rev. 2017 Sep;38:6-17. DOI: http://dx.doi.org/10.1016/j.arr.2017.06.003

BACKGROUND: Older people constitute a significant proportion of the total population and their number is projected to increase by more than half by 2030. This increasing probability of late survival comes with considerable individual, economic and social impact. Physical activity (PA) can influence the ageing process but the specific relationship with healthy ageing (HA) is unclear.

METHODS: We conducted a systematic review and meta-analysis of longitudinal studies examining the associations of PA with HA. Studies were identified from a systematic search across major electronic databases from inception as January 2017. Random-effect meta-analysis was performed to calculate a pooled effect size (ES) and 95% CIs. Studies were assessed for methodological quality.

RESULTS: Overall, 23 studies were identified including 174,114 participants (30% men) with age ranges from 20 to 87 years old. There was considerable heterogeneity in the definition and measurement of HA and PA. Most of the identified studies reported a significant positive association of PA with HA, six reported a non-significant. Meta-analysis revealed that PA is positively associated with HA (ES: 1.39, 95% CI = 1.23–1.57, n = 17) even if adjusted for publication bias (ES: 1.27, 95% CI = 1.11–1.45, n = 20).

CONCLUSIONS: There is consistent evidence from longitudinal observational studies that PA is positively associated with HA, regardless of definition and measurement. Future research should focus on the implementation of a single metric of HA, on the use of objective measures for PA assessment and on a full-range of confounding adjustment.

129. **Physician Re-Entry: I'll Be Back.** M. M. Deren. Connecticut medicine. 2015;79(9):567-568.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26630712

130. **Physician retirement: gender, geography, flexibility and pensions.** M. P. Silver. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2017;189(49):E1507-E1508. https://dx.doi.org/10.1503/cmaj.171302

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=29229711

131. **Planning is essential when dealing with physician retirement.** S. Geis. MGMA connexion. 2017;17(1):42-43.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=30376265

132. **Practise till you drop: Trialing an online intervention for late-career medical practitioners to promote planning for retirement.** Mooney A, **Wijeratne C**, Earl JK, Gordon J.Internet Interv. 2021 Sep 9;26:100452. doi: 10.1016/j.invent.2021.100452. eCollection 2021 Dec.

Many medical practitioners in Australia work beyond the traditional retirement age. Transitioning to retirement is important, however, because the likelihood of poorer clinical outcomes increases with practitioner age. The objective of the present study was to develop and trial an online educational intervention to promote planning for a smoother transition to retirement using a non-randomized control group pre- and post-test design. Medical practitioners aged 55 or over (*N* = 262, *Mage* = 61.9) and working 30 or more hours per week were recruited to complete four online modules that addressed a range of topics (physical, health, financial, social, cognitive, and emotional well-being) and encouraged planning for retirement resources. Outcome measures included work centrality, mastery, and goal perceptions across the aforementioned resource domains. Eighty-one doctors completed post-training measures; a control group who completed only the measures (*n* = 23) and a training group (*n* = 58). Pre-post comparisons showed no significant changes for the control group. However, the training group at Time 2 showed lower work centrality $t(57) = 2.12$, ($p = .036$), and changes to social $t(57) = 2.35$, ($p = .022$), emotional $t(57) = 3.18$, ($p = .002$) and health goal perceptions $t(57) = -2.02$, ($p = .049$). Controlling for baseline scores and self-selection bias determinants, Generalized Linear Model (GLM) analyses indicated a training group increase in mastery scores ($\beta = 0.87$, $p = .045$) and decrease in negative perception of the consequence of not meeting emotional goals ($\beta = -0.37$, $p = .043$). Although not significant, GLM results also showed an increase in resources, three of four health goal domains and financial goals, indicating the potential for positive training effects in future applications of the program. The online retirement planning resource showed promise in promoting a sense of mastery and a reassessment of retirement plans, taking into consideration resource accumulation and goal setting across five specific goal domains. We discuss the theoretical and practical implications of our findings.

133. **Professional and psychosocial factors affecting the intention to retire of Australian medical practitioners**. Wijeratne C, Earl JK, Peisah C, Luscombe GM, Tibbertsma J. Med J Aust. 2017 Mar 20;206(5):209-214. doi: 10.5694/mja16.00883.PMID: 28301791

OBJECTIVE: To determine the professional and personal factors associated with the intention to retire (ITR) by medical practitioners.

DESIGN, PARTICIPANTS AND SETTING: Cross-sectional survey of currently practicing Australian doctors aged 55 or older registered with a commercial database. Participants completed an online self-report questionnaire in October 2015.

MAIN OUTCOME MEASURES: Associations between intention to retire and demographic and practice characteristics; health; emotional, social and financial resources; work centrality; and anxiety about ageing.

RESULTS: 62.0% of 1048 respondents (17.5% response rate) intended to retire, 11.4% had no intention of retiring and 26.6% were unsure. The odds of retiring were higher for those with adequate financial resources (adjusted odds ratio [aOR], 1.31; 95% CI, 1.18-1.44) and greater anxiety about ageing (aOR, 1.05; 95% CI, 1.02-1.09); the odds of retiring were lower for international medical graduates (aOR, 0.61; 95% CI, 0.44-0.85), for those with greater work centrality (aOR, 0.89; 95% CI, 0.85-0.92) and greater emotional resources (aOR, 0.96; 95% CI, 0.93-0.98). In a model including medical specialty as a variable, being a psychiatrist (aOR, 0.40; 95% CI, 0.20-0.79) or general practitioner (aOR, 0.54; 95% CI, 0.34-0.87) were associated with reduced odds of intending to retire.

CONCLUSION: Intention to retire was determined by a mixture of professional and psychosocial characteristics. In particular, our results support the view that delaying retirement by doctors may be related to the primacy of work compared with other life roles. Our results may be used to develop educational programs that support the transition to and improve adjustment to retirement.

134. **Reimagining the self at late-career transitions: how identity threat influences academic physicians' retirement considerations.** B. Onyura, J. Bohnen, D. Wasylenki, A. Jarvis, B. Giblon, R. Hyland, I. Silver and K. Leslie. Academic medicine: journal of the Association of American Medical Colleges. 2015;90(6):794-801. https://dx.doi.org/10.1097/ACM.0000000000000718

PURPOSE: There is scant empirical work exploring academic physicians' psychosocial adjustment during late-career transitions or on the factors that influence their retirement decisions. The authors examine these issues through the lens of sociopsychological identity theory, specifically examining how identity threat influences academic physicians' decisions about retirement.

METHOD: Participants were academic physicians at a Canadian medical school and were recruited via e-mail requests for clinical faculty interested in discussing late-career and retirement planning issues. Participants included 15 males and 6 females (N = 21; mean age = 63, standard deviation = 7.54), representing eight specialties (clinical and surgical). Data were collected in October and November 2012 via facilitated focus groups, which were digitally recorded, transcribed verbatim, and anonymized, then analyzed using thematic analysis.

RESULTS: Four primary themes were identified: centrality of occupational identity, experiences of identity threat, experiences of aging in an indifferent system, and coping with late-career transitions. Identity threats were manifested in apprehensions about self-esteem after retirement, practice continuity, and clinical competence, as well as in a loss of meaning and belonging. These identity challenges influenced decisions on whether to retire. Organizational and system support was perceived as wanting. Coping strategies included reimagining and revaluing various aspects of the self through assimilating new activities and reprioritizing others.

CONCLUSIONS: Identity-related struggles are a significant feature of academic physicians' considerations about late-career transitions. Understanding these challenges, their antecedents, and their consequences can prepare faculty, and their institutions, to better manage late-career transitions. Individual- and institution-level implications are discussed.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=25881649

135. **Reluctance to Retire: A Qualitative Study on Work Identity, Intergenerational Conflict, and Retirement in Academic Medicine.** M. P. Silver and S. A. Williams. The Gerontologist. 2018;58(2):320-330. https://dx.doi.org/10.1093/geront/gnw142

    PURPOSE OF THE STUDY: Some professions foster expectations that individuals cultivate their work identity above all other aspects of life. This can be problematic when individuals are confronted with the expectation that they will readily terminate this identity in later-career stages as institutions seek to cycle in new generations. This study examines the relationship between work identity and retirement by examining multiple generations of academic physicians.

    DESIGN AND METHODS: This study used a multimethod qualitative design that included document analysis, participant observation, focus groups, and in-depth interviews with academic physicians from one of the oldest departments of medicine in North America.

    RESULTS: This study illustrates how participants were predisposed and then groomed through institutional efforts to embrace a career trajectory that emphasized work above all else and fostered negative sensibilities about retirement. Participants across multiple generations described a lack of work-life balance and a prioritization of their careers above nonwork commitments. Assertions that less experienced physicians were not as dedicated to medicine and implicit assumptions that later-career physicians should retire emerged as key concerns.

    IMPLICATIONS: Strong work identity and tensions between different generations may confound concerns about retirement in ways that complicate institutional succession planning and that demonstrate how traditional understandings of retirement are out of date. Findings support the need to creatively reconsider the ways we examine relations between work identity, age, and retirement in ways that account for the recent extensions in the working lives of professionals.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=27586874

136. **Retirement ages of senior UK doctors: national surveys of the medical graduates of 1974 and 1977.** F. Smith, M. J. Goldacre and T. W. Lambert. BMJ open. 2018;8(6):e022475. https://dx.doi.org/10.1136/bmjopen-2018-022475

    OBJECTIVE: To report on retirement ages of two cohorts of senior doctors in the latter stages of their careers.

    DESIGN: Questionnaires sent in 2014 to all medical graduates of 1974 and 1977.,

    SETTING: UK., PARTICIPANTS: 3695 UK medical graduates.

    MAIN OUTCOME MEASURES: Retirement status by age at the time of the survey and age at retirement if retired. Planned retirement ages and retirement plans if not retired.

    RESULTS: Of contactable doctors, 85% responded. 43.7% of all responding doctors had fully retired, 25.9% had 'retired and returned' for some medical work, 18.3% had not retired and were working

full-time in medicine, 10.7% had not retired and were working part-time in medicine and 1.4% were either doing non-medical work or did not give details of their employment status. The average actual retirement age (including those who had retired but subsequently returned) was 59.6 years (men 59.9, women 58.9). Psychiatrists (58.3) and general practitioners (GPs) (59.5) retired at a slightly younger age than radiologists (60.4), surgeons (60.1) and hospital specialists (60.0). More GPs (54%) than surgeons (26%) or hospital medical specialists (34%) were fully retired, and there were substantial variations in retirement rates in other specialties. Sixty-three per cent of women GPs were fully retired.

CONCLUSIONS: Gender and specialty differences in retirement ages were apparent and are worthy of qualitative study to establish underlying reasons in those specialties where earlier retirement is more common. There is a general societal expectation that people will retire at increasingly elderly ages; but the doctors in this national study retired relatively young.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=29950479

137. **The Retirement Paradox**. M.P. Silver. Contexts. 2023.;22(2): 24-29. https://doi.org/10.1177/15365042231172461

A discussion of the inherent tension between the idea of retirement being one of unstructured exploration and our personal need for structure, the maintenance of meaningful relationships and connections, identity and personal fulfilment.

138. **Retirement patterns of Australian doctors aged 65 years and older.** C. M. Joyce, W. C. Wang and H. M. McDonald. Australian health review: a publication of the Australian Hospital Association. 2015;39(5):582-587. https://dx.doi.org/10.1071/AH14176

OBJECTIVE: To investigate retirements over a 4-year period among Australian general practitioners (UPs) and specialists aged 65 years and over, and factors influencing retirement., METHODS: Data from Medicine in Australia: Balancing Employment and Life (MABEL) for the years 2009-12 were analyzed for 435 GPs and 643 specialists aged 65 years and over at the time of entry to the MABEL survey. Discrete time survival analysis was used., RESULTS: The retirement rates were 4.1% (2009), 5.1% (2010), 4.2% (2011) and 10.4% (2012). Retirement was associated with: (1) the intention to leave medical work in 2009 and 2010; (2) working fewer hours in private consulting rooms in 2010 and 2012; (3) having lower job satisfaction in 2009 and 2011; (4) being older in 2009; (5) working fewer hours in a public hospital in 2012; and (6) working fewer hours in a private hospital in 2010. Doctors who intended to reduce their working hours were less likely to retire in 2009., CONCLUSIONS: Strategies to support doctors at the late career stage to provide their valued contributions to the medical workforce for as long as possible may include increasing job satisfaction and addressing barriers to reducing work hours.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26093885

139. **Retirement plan options for pensionless physicians.** B. Owens. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2019;191(36):E1014-E1015. https://dx.doi.org/10.1503/cmaj.1095795

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=31501189

140. **Retiring in a white coat: Doctors working after retirement.** S. Manor and R. Holland. Journal of Vocational Behavior. 2022;133:1-12. https://dx.doi.org/10.1016/j.jvb.2021.103678

    Work constitutes a central component of a person's identity. Retirement, which is a significant change in life, also affects the way one's identity is established upon entering this new stage in life. Continuing to work after retirement enables individuals to maintain their professional identity alongside their retirement identity, thus facilitating the transition and entry into a new stage of life. The current study uses in-depth interviews to examine post-retirement working among Israeli doctors who have retired over the past few years but continue to work. The findings show that doctors have difficulty shedding their professional identity since the medical profession was, and still is, central to their overall identity. They thus experience retirement as a forced event rather than a desirable transition. However, by continuing to work, they preserve their status as doctors, which imparts a feeling of still being needed and thus enhances their self-image. Working beyond retirement allows doctors to put off the advent of old age and to avoid self-definition as retired persons, thus allowing them to preserve their professional status and hybrid identity. (PsycInfo Database Record (c) 2022 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc21&NEWS=N&AN=2022-32372-001

141. **Retiring physicians: Maintenance and destruction of medical records.** B. S. Herrin. Journal of the Medical Association of Georgia. 2015;104(2):32.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26489283

142. **Review of The three stages of a physician's career: Navigating from training to beyond retirement.** S. Kahle. Families, Systems, & Health. 2018;36(3):416-417. https://dx.doi.org/10.1037/fsh0000372

    Reviews the book, The Three Stages of a Physician's Career: Navigating From Training to Beyond Retirement edited by Neil H. Baum, Joel M. Blau, Peter S. Moskowitz, and Ronald J. Paprocki (2017). This step-by-step guide for physicians (although somewhat germane to other health care providers) advises clinicians about molding and self-managing their career to cultivate the most satisfying trajectory. Uniquely, the book provides a detailed examination of physicians' career development, highlighting challenges and expectations physicians encounter while matriculating through critical career changes. Each milestone requires a different strategy and approach, as described in the three sections of the book. The book concludes with strategies on how to manage life after a medical career. Whereas the book is valuable for physicians and other health care professionals, some content is limited to independent practice settings. (PsycInfo Database Record (c) 2022 APA, all rights reserved)

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc17&NEWS=N&AN=2018-41556-001

143. **Road to Retirement: Not Necessarily the Road Less Traveled--Part I.** J. M. Blau, R. J. Paprocki and N. Baum. The Journal of medical practice management: MPM. 2015;30(6):373-376.

    This article is the first of a three-part series that discusses the steps toward a successful retirement. This part reviews Social Security benefits, provides suggestions for selecting the timing for accepting Social Security benefits, and offers an explanation of individual retirement accounts. The article also acts as a checklist for retirement.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26182700

144. **Road to Retirement: Part II--Advice on Advisors.** J. M. Blau, R. J. Paprocki and N. Baum. The Journal of medical practice management: MPM. 2015;31(1):26-28.

    Retirement is a process that usually and fortunately happens just once in a doctor's lifetime. If the retiring doctor makes plans long before the retirement date and has good guidance from his or her advisors, then he or she will be financially secure and able to enjoy the post practice years. This article discusses the importance of advisors and how to select one(s) that will lead you to a happy retirement.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26399033

145. **Road to Retirement Part III: Other Options for Retiring Physicians.** J. M. Blau, R. J. Paprocki and N. Baum. The Journal of medical practice management: MPM. 2015;31(2):78-81.

    Retirement provides many opportunities for physicians in this stage of their lives. This final installment of the three-part series on retirement discusses the post-retirement options that physicians can avail themselves of when they leave the conventional practice of medicine. We will also provide a checklist for the retiring doctor.

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med12&NEWS=N&AN=26665472

146. **'Should I stay or should I go now?': A qualitative study of why UK doctors retire.** J. Cleland, T. Porteous, O.-Z. Ejebu and D. Skatun. Medical education. 2020;54(9):821-831. https://dx.doi.org/10.1111/medu.14157

    OBJECTIVES: Health care delivery and education face critical potential shortages in the foreseeable future in terms of retaining doctors nearing the time of retirement - doctors who have experience-based knowledge to pass onto the next generation. Retirement decisions are driven by a combination of macro-related, job and individual factors. This is a constantly shifting space; findings from earlier studies do not always help us understand the retirement decisions of contemporary cohorts of doctors. To address these issues and identify new knowledge to inform approaches to retaining expertise, we aimed to identify and explore what may keep an older doctor in the workforce ('stay') factors and ('go') factors that might prompt retirement.

METHODS: We invited doctors aged 50 years or over from diverse areas of Scotland to participate in qualitative, semi-structured interviews. Initial analysis of interview transcripts was inductive. The embeddedness theory of Mitchell et al encompassing the dimensions of 'link,' 'fit' and 'sacrifice,' was used for subsequent theory-driven analysis.

RESULTS: A total of 40 respondents participated. In terms of 'link,' retiring could feel like a loss when work links were positive, whereas the opposite was true when relationships were poor, or peers were retiring. Considering 'fit,' intrinsic job satisfaction was high, but respondents had less confidence in their own abilities as they grew older. However, the data foregrounded the inverse of the notion of Mitchell et al's 'sacrifice'; for UK doctors, staying in work can involve sacrifice because of tax penalties, work intensity and arduous demands.

CONCLUSIONS: Retirement stay and go factors seem enmeshed in the cultural, social and economic structures of health care organizations and countries. Systems-level interventions that address ultimate causes, such as sufficient staffing, supportive systems, non-punitive taxation regimes and good working conditions are likely to be most effective in encouraging doctors to continue to contribute their knowledge and skills to the benefit of patients and learners.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med17&NEWS=N&AN=32181908

147. **Should Physicians Ever Retire?** C. W. Van Way, 3rd. Missouri medicine. 2017;114(2):78-79.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=pmnm4&NEWS=N&AN=30228541

148. **A systematic review of physician retirement planning.** M. P. Silver, A. D. Hamilton, A. Biswas and N. I. Warrick. Human resources for health. 2016;14(1):67. https://dx.doi.org/10.1186/s12960-016-0166-z

BACKGROUND: Physician retirement planning and timing have important implications for patients, hospitals, and healthcare systems. Unplanned early or late physician retirement can have dire consequences in terms of both patient safety and human resource allocations. This systematic review examined existing evidence on the timing and process of retirement of physicians. Four questions were addressed: (1) When do physicians retire? (2) Why do some physicians retire early? (3) Why do some physicians delay their retirement? (4) What strategies facilitate physician retention and/or retirement planning?

METHODS: English-language studies were searched in electronic databases MEDLINE, Web of Science, Scopus, CINAHL, AgeLine, Embase, HealthSTAR, ASSA, and PsycINFO, from inception up to and including March 2016. Included studies were peer-reviewed primary journal articles with quantitative and/or qualitative analyses of physicians' plans for, and opinions about, retirement. Three reviewers independently assessed each study for methodological quality using the Newcastle-Ottawa Scale for quantitative studies and Critical Appraisal Tool for qualitative studies, and a fourth reviewer resolved inconsistencies.

RESULTS: In all, 65 studies were included and analyzed, of which the majority were cross-sectional in design. Qualitative studies were found to be methodologically strong, with credible results

deemed relevant to practice. The majority of quantitative studies had adequate sample representativeness, had justified and satisfactory sample size, used appropriate statistical tests, and collected primary data by self-reported survey methods. Physicians commonly reported retiring between 60 and 69 years of age. Excessive workload and burnout were frequently cited reasons for early retirement. Ongoing financial obligations delayed retirement, while strategies to mitigate career dissatisfaction, workplace frustration, and workload pressure supported continuing practice.

CONCLUSIONS: Knowledge of when physicians plan to retire and how they can transition out of practice has been shown to aid succession planning. Healthcare organizations might consider promoting retirement mentorship programs, resource toolkits, education sessions, and guidance around financial planning for physicians throughout their careers, as well as creating post-retirement opportunities that maintain institutional ties through teaching, mentoring, and peer support.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=27846852

149. **Thank you for letting me be your physician.** D. M. Gelfman. Patient Education and Counseling. 2021;104(12):2888-2889. https://dx.doi.org/10.1016/j.pec.2021.02.015

    I believe this article emphasizes how emotionally valuable receiving patients' trust is to the practicing physician. It also gives new insight into understanding the emotional loss a physician may experience when leaving private practice, even if they remain active in medicine. Finally, for those entering medicine, it explains the profound personal satisfaction they can experience from long-term trusting relationships with patients. (PsycInfo Database Record (c) 2022 APA, all rights reserved)

    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc20&NEWS=N&AN=2022-13064-003

150. **The Unbearable Lightness of Being Retired.** M.P. Silver Can J Aging. 2019 Mar;38(1):21-34. DOI: 10.1017/S0714980818000466.

    In this qualitative study, I followed an approach to examine perceptions about retirement, using an interview guide informed by the life course perspective, among 26 men and women who had retired from positions as chief executive officers. Three key themes emerged: (1) the importance of productivity and networking as participants rose up the corporate ladder; (2) the sense of having a "best before" date and experiencing societal pressures to retire; and (3) struggles with feeling insignificant in retirement while desiring personal fulfillment through continued engagement in paid work. These findings shed light on the value of using a life course perspective to examine retirement as both a personal experience and as a social phenomenon. Findings also contribute to theoretical understandings of productive aging by illustrating how preconceptions about productivity contrast with ideations of a leisure-filled retirement in ways that can foreshorten the employment contributions of some individuals.

151. **The Warmest of Handoffs: A Neighborhood Physician's Transfer of Care.** A. B. Reichsman and C. Meador. Annals of family medicine. 2023;21(4):372-373. https://dx.doi.org/10.1370/afm.2991

Transitioning care of a patient from an outgoing to an incoming physician provides a precious opportunity to transfer knowledge and trust. We explore this process from the perspectives of 2 practitioners, an incoming physician who recently completed training and a retiring physician leaving a practice of 40 years. The method we arrived at for this transfer provided the space for collaboration on what the essence of caring for a unique individual will entail. We discovered that a handoff of care is the intergenerational transfer of culture. It involves worrying and watching and relaxing into hopefulness. It is both witnessing and launching a life's work. It is reliving and inheriting and reinventing relationship. Copyright © 2023 Annals of Family Medicine, Inc.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med24&NEWS=N&AN=37487723

152. **"Why give up something that works so well?": Retirement expectations among academic physicians.** M. P. Silver, N. C. Pang and S. A. Williams. Educational Gerontology. 2015;41(5):333-347. https://dx.doi.org/10.1080/03601277.2014.970419

For individuals with strong work identities, the decision to retire can be particularly challenging. For academic physicians, retirement is an important personal decision that also has far-reaching implications for the healthcare system. This is because academic physicians are responsible for producing the research from which key medical decisions are made, for training future healthcare providers, and for providing specialized care for patients. For this study, we conducted focus groups with academic physicians from a large research university in Canada and then performed inductive thematic analyses to examine perceptions and concerns about later life career transitions. This study highlights tensions between professional experiences for the next generation of physicians and individual struggles with personal identity. Findings suggest improvements to institutional programs that support flexible, agentive, and respectful retirement transitions will not only be beneficial but necessary as medical and university systems continue to grapple with issues of balanced recruitment and succession. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc14&NEWS=N&AN=2015-00493-001

153. **Why No Mandatory Retirement Age Exists for Physicians: Important Lessons for Employers.** B. Grandjean and C. Grell. Missouri medicine. 2019;116(5):357-360.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med16&NEWS=N&AN=31645776

154. **Will the Real Physician Retirees Please Stand Up?.** L. Hedden, M. R. Lavergne, K. M. McGrail, M. R. Law, L. Cheng, M. A. Ahuja and M. L. Barer. Healthcare policy = Politiques de sante. 2018;14(2):32-39. https://dx.doi.org/10.12927/hcpol.2018.25688

Policy makers and health workforce planners rely on counts of practice licenses as a measure of the size of the active physician workforce. We use a population-based approach to correlate estimates of retirement from clinical care based on these data with those produced using physician payment data. We find that licensure data generates per-capita estimates of physician supply in British Columbia that are substantially higher than activity-based estimates. Licensure data are unlikely to

produce reliable estimates of the timing and extent of physician retirement and therefore should not be used as the primary basis for estimating current or future physician supply. Copyright © 2018 Longwoods Publishing.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med15&NEWS=N&AN=30710439

155. **Won't you stay just a little bit longer? A discrete choice experiment of UK doctors' preferences for delaying retirement.** J. Cleland, T. Porteous, O.-Z. Ejebu, M. Ryan and D. Skatun. Health policy (Amsterdam, Netherlands). 2022;126(1):60-68. https://dx.doi.org/10.1016/j.healthpol.2021.11.004

INTRODUCTION AND AIMS: Health systems around the world face difficulties retaining their workforce, which is exacerbated by the early retirement of experienced clinicians. This study aims to determine how to incentivize doctors to delay their retirement.,

METHODS: We used a discrete choice experiment to estimate the relative importance of job characteristics in doctors' willingness to delay retirement, and the number of extra years they were willing to delay retirement when job characteristics improved. 2885 British Medical Association members aged between 50 and 70 years, registered with the General Medical Council, practicing in Scotland (in December 2019), and who had not started to draw a pension were invited. We compared the preferences of hospital doctors (HDs) and general practitioners (GPs).

RESULTS: The response rate was 27.4% (n = 788). The number of extra years expected to work was the most important job characteristic for both respondents, followed by work intensity for GPs, whereas working hours and on-call were more important for HDs. Personalized working conditions and pension taxation were the least important characteristics for both groups. Setting all characteristics to their BEST levels, GPs would be willing to delay retirement by 4 years and HDs by 7 years., CONCLUSIONS: Characteristics related to the job rather than pension could have the greatest impact on delaying retirement among clinicians. Copyright © 2021. Published by Elsevier B.V.

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med21&NEWS=N&AN=34887102

DEPARTMENTAL & HOSPITAL SUPPORT DOCUMENTS FOR LATE CAREER TRANSITIONING

UNIVERSITY HEALTH NETWORK

UHN Physician Late Career Guidelines

Updated January 30, 2025 (addition of information about the HOOPP for physicians; addition of podcast resources; addition of CPSO resignation information)

Vision:
UHN's physicians will feel valued, professionally fulfilled, and competent in their contributions to the clinical, academic, and research mission of UHN at all stages of their careers, and feel professionally, personally, and financially prepared for transitions in their work from late career through to retirement from clinical practice at UHN.

Goals:

1. Provide guidance to UHN's physician leaders in support of UHN's physicians in their transition from late career through to retirement.
2. Provide options for physicians to consider as they move through late career toward retirement. We aim to accomplish this through encouraging meaningful and flexible opportunities for continued contribution to the work of UHN, and opportunities for gradual changes in practice that are beneficial and agreeable to the individual physician, their Department and Program, and UHN; while upholding UHN's values of safety, compassion, teamwork, integrity, and stewardship, and ensuring the needs of patients come first.

Planning Ahead - Suggestions for Heads of Programs, Departments, Divisions

- All conversations should take place with the utmost sensitivity and respect, recognizing the importance of work to self-identity, and explicitly recognizing the contributions of the individual
- Ideally, conversations about a physician's career plan, ambitions, and expectations are included in every physician's annual review prior to reappointment, during which each physician's plan and goals for the next 3-5 years are discussed, including consideration of any barriers and facilitators anticipated in fulfilling this plan or reaching these goals, and how the leader can assist with aspects within the control of the leader
- We encourage supportive discussions regarding work-life balance, health maintenance (physical and mental), and outside interests (demonstrating there is life outside of and after medicine and surgery), throughout the career span
- Identify and manage possible deterioration of physical and cognitive abilities at all stages of a physician's career, and consider what supports and/or adjustments to duties may be required
- We encourage conversations about plans for late career transitions and eventual retirement to start mid-career, by age 60 at the latest, during the annual reappointment meeting/review, in order to ensure physicians are prepared for changes they may wish to make, and for the Program, Department and/or Division to effectively plan for transitions in human resources, reducing the possibility of sudden loss of services
- Consider UHN/Program/Department/Division needs, and individual goals and plans of physicians; find alignment where possible
- Consider how resource allocation may change based on the strategic direction of UHN, Departments, Programs, and Divisions, and provide notice of changes as early as possible

- Consider options the Program/Department/Division may offer to physicians who are transitioning in late career toward eventual retirement (roles, reduction in clinical and on-call hours and/or protected time for academic and leadership responsibilities, office space, access to email job sharing, administrative) and how these contributions will be defined, evaluated for alignment with program needs, and reviewed annually; consider implications for Practice Plans and workload
- Any agreements regarding changes in practice should be in writing
- Consider engaging recently retired and late career physicians for a peer discussion group that is participant-led, focusing on planning for late career/retirement, speakers on relevant subjects (financial planning, how to maintain meaning and purpose, staying relevant, maintaining good health), or take advantage of third-party offerings (U of T, OMA, CMPA, MD Management, etc.); within Department/Division, or across Department/Division
- Consider engaging late career physicians for a Mentorship/Allyship support position for physicians involved in serious safety events; who have experienced suboptimal patient outcomes; who wish to receive career guidance; who require accommodation; who are interested in University promotion; who require support for conflict resolution, etc.

Planning Ahead- Suggestions for Individual Physicians

- Throughout the stages of a physician's career, physicians will benefit from routine engagement in honest self-reflection of their health; practice performance and competence; ability to adapt to changing models of care, technology, and therapeutic advancements; and, ability to provide safe, quality care to patients
- Consider that adequate late career and retirement planning will serve to enhance well-being and control over one's career
- Engage in interests outside of medicine and surgery, throughout career, and find belonging in social groups outside of the hospital
- Recognize that allocation of hospital resources must remain in alignment with the strategic direction of the hospital and program/department/division, and the needs of patients, and thus access to resources may change over time

- Financial planning:

  Important at all stages of a physician's career
  - Consult with a financial advisor, accountant or lawyer to create a viable financial plan and better prepare for late career transitions and eventual retirement
  - Ensure your savings will be sufficient to meet your expenses, along with Canada Pension Plan (CPP) benefits and Old Age Security (OAS) benefits, if applicable
  - Consider joining HOOPP (Healthcare of Ontario Pension Plan), if you practice as a Medical Professional Corporation (MPC) (this pension plan is open to incorporated physicians as of January 2025)
  - Consider contributing to a private registered pension plan for physicians throughout career
  - Create a personal Will (and Corporate Will if applicable) to communicate your wishes for your estate and communicate same to your executor and beneficiaries

- Consider insurance – life, disability, critical illness
- Consider options for an "encore career", that will use your skills and experience while maintaining meaning and connection, and perhaps income

- Non-Financial planning:
  - Plan for your ideal personal life – what do you hope late career and retirement will look like for you on a personal level? Consider lifestyle, health, family, housing, personal interests, social engagement, community involvement, travel, support of loved ones
  - Consider how you will emotionally manage the transition to retirement, considering, for example, possible loss of self-identity. Support available through the Physician Health Program.
  - Appoint an attorney for personal care through power of attorney and communicate your wishes to the person appointed
  - Tool for reflection: "My plan for transitioning to retirement"

Fee Reduction

- CMPA fees – fees can be significantly lower when a physician's practice changes scope; for example, while 2024 CMPA fees for General Surgery are $16,368.00 in Ontario, "Assistance at surgery" fees are reduced to $2,904.00.
- CPSO fees – 2024 annual fee is $1725.00; physicians can apply for a fee reduction based on reduced clinical activities related to health or unexpected life events; reduced to $0 when resign from membership and have ceased all clinical practice activities.
- OMA – dues are not mandatory for retired physicians
- RCPSC – fees are waived for Retired Fellows (retired from all medical or health-related professional activities, no longer carry a license from a medical regulatory authority, and not in part-time practice or reduced-scope practice, such as surgical assisting or teaching); fee reductions for those with reduced net professional income (up to $115,000/year)
- CFPC – special fee consideration (reduction) for active members who are working fewer than 20 hours/week; non-practising members (no longer actively engaged in providing medical care to patients, nor actively involved in any other medical or medically-related field or endeavor) do not pay annual fees

Emeritus/Emerita Designations

"Professor Emeritus/Emerita" at University of Toronto – Those who retire with the academic rank of full professor or associate professor may request the honorary title of Professor Emeritus/Emerita via the University's process; associate professors may be eligible if they are deemed to have made a substantial contribution to the University. Emeritus/Emerita status includes retention of library access, tuition waivers for self and dependents, scholarships for dependents, access to the Senior College, institutional email, and computer access. The approval process may be lengthy (over six months).

"Retired Fellow" status at Royal College of Physicians and Surgeons of Canada - If you have relinquished your medical licence, or are about to, may submit a Confirmation of Retired Status form to the Royal College. As a retired Fellow, you retain the use of your designation and remain a member of the Royal College.

Actions to Retire

UHN requirements:

1. Review the UHN Physician Departure policy to understand the requirements of UHN
2. Follow the UHN Physician Departure Checklist
3. Consult with UHN's People & Culture physician representatives, Dharsha Quintero or Bhavya Iyengar, to understand financial and other obligations regarding your staff

University of Toronto:

1. Discuss your retirement plan with applicable University of Toronto Division Director and Department Chair

CPSO, OMA, CMPA, HealthForceOntario, RCPSC, CFPC:

1. Review the CPSO policy Closing a Medical Practice and accompanying Advice to the Profession: Closing a Medical Practice.
2. Formally resign from CPSO membership via the Member Portal.
3. Review the OMA guides Closing your Practice and Closing your practice due to retirement? FAQ
4. Review CMPA guide Closing or leaving a practice: Tips for physicians
5. Review HealthForceOntario guide Transition Out of Practice: A Guide for Physicians
6. Advise RCPSC of your intention to retire RCPSC Confirmation of Retired Status form

Additional Resources - Perspectives on Planning for Retirement and the Retirement Experience

- Late Career Transitions & Physician Retirement Reading/Resource List, Temerty Faculty of Medicine.
- "Retirement and Its Discontents: Why we won't stop working, Even if we Can" by Michelle Panor Silver, Chair of U of T's Department of Health and Society Publisher Retail links
- Sight set on retirement (Dr. Graham Trope, UHN)
- Preparing for Retirement (Dr. Liesly Lee, U of T)
- A Personal Perspective on the 'Big R'- Retirement (Professor Emerita Anne Kenshole, U of T)
- Retirement: Highlights of a new sunset (Professor Emeritus George Fantus, U of T)
- Looking Back: A Retirement Interview Series (UBC)
- Physician Retirement: How to know when it's time (Dr. Heidi Moawad)
- Lost in Transition? Thoughts on Retirement, Part 2. "Should I Stay or Should I Go Now?" (Commentary, The Oncologist)
- Reinvention or Being Carried Out in a Box: Non-Financial Aspects of Physician Retirement (Handout, Presentation at AGM of the Society of Teachers of Family Medicine)
- Retirement Readiness Tool (Doctors Manitoba)
- Podcast episodes:
    - "What Comes Next? A Physician's Retirement Story - with Dr. Bob Rosen", *Doctors Eyes Only,* ep. 11, June 30, 2021, 37 minutes.

- As a physician, the thought of retirement can be anxiety-inducing. You are used to working endless hours in your practice and then all that stops – what comes next? In this episode, Lauren Oschman and Kameron Helmuth are joined by retired emergency medicine physician, Dr. Bob Rosen, as they discuss Bob's journey into retirement.

- "Working Less is Worth Every Penny", *Optimal Finance Daily*, ep. 2047, September 29, 2022, 13 minutes.
    - Episode 2047: Working Less is Worth Every Penny by Leif of Physician on Fire - Leif is a former anesthesiologist, a family man, and a supposed outdoors enthusiast who spends way too much time indoors. Physician on FIRE is a personal finance website he created to inform and inspire both physicians and our patients with insightful writing from a physician who has attained financial independence and the ability to retire early. The site has a triple aim to leave visitors enlightened, educated, and entertained.
- "An Alternative to Traditional Retirement: Considerations for Physicians", *Sound Practice*, January 27, 2021, 37 minutes.
    - Most physicians follow or supplement their clinical practice with physician leadership roles, and wind down their careers by scaling back to part time executives or clinical consultants before official retirement. Richard Afable, MD, MPH, FACP, suggests an alternative. After retiring from CEO and executive roles at several large health systems, Dr. Afable now advocates for community wellbeing and the development of others as the President and Board Chair of BeWellOC in Orange County. In this episode, we interview Dr. Afable about how physicians can (and should) plan for a type of "third career" - one that focuses on significance and service. He also shares concepts that physicians can consider as they work towards a retirement plan.
- "How To Get Ready for Retirement After a Career in Pediatrics", *The Pediatric Lounge*, ep. 129 (s.2, e.53), February 27, 2024, 67 minutes.
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UNIVERSITY OF TORONTO

1. **Department of Medicine**: The Department of Medicine believes that transition toward pre-retirement and through retirement should be a planned and rewarding part of one's academic medical career. We want to promote a culture change that turns career transition into a planned and fulfilling process.

   The Culture & Inclusion (C&I) portfolio has created a document to provide practical advice to faculty members to facilitate planning for the late career transition process and to support our late career faculty members (who are either contemplating or deciding to retire) in a respectful, thoughtful, and compassionate manner.

   Link: https://deptmedicine.utoronto.ca/sites/default/files/inline-files/LATE CAREER TRANSITION_Jan30.pdf

BOOKS

RETIREMENT AND LIVING WELL

1. ***Decisive: How to Make Better Choices in Life and Work***
   By: Chip Heath and Dan Heath
   - Good guide to the cognitive psychology of decision-making.

2. ***From Strength to Strength: Finding Meaning, Success, and Deep Purpose in the Second Half of Life.***
   By: Arthur C. Brooks
   - A roadmap for finding purpose, meaning, and success as we age.

3. ***Growing Young: How Friendship, Optimism, and Kindness Can Help You Live to 100***
   By: Marta Zaraska
   - What to focus on to live long and well.

4. ***How to Do Nothing: Resisting the Attention Economy***
   By: Jenny Odell
   - A self-help book which explores the value of doing nothing in a world obsessed with busyness and productivity. It incorporates practical exercise and insightful anecdotes to encourage readers to question their constant need to be engaged.

5. ***Ikigai: The Japanese Secret to a Long and Happy Life***
   By: Hector Garcia and Francesc Miralles
   - An approach to discovering what you want to do with your time.

6. ***Independence Day: What I Learned About Retirement from Some Who've Done It and Some Who Never Will***
   By: Steve Lopez
   - A memoir by 68 y/o man trying to convince himself not to retire (helpful as it outlines different views of "retirement" and "in between" pathways)

7. ***What Color Is Your Parachute? – Your guidebook to a lifetime of meaningful work and career success*** *(2022 version)*
   By: Richard N Bolles
   - A classic text updated for the digital age; good for the person who sees "retirement" as a chance to contribute actively in a different way.

RETIREMENT AND PHYSICIANS

1. ***From* residency to retirement: Physicians' careers over a professional lifetime.**
   By: Terry Mizrahi (2021)
   - In the United States, becoming a doctor has long been considered one of the best career choices. In 2016 to 2017, according to the Association of American Medical Schools, approximately 52,000 people applied to go medical school (2017). In 2015 there were nearly a million licensed physicians in the United States. In 1986 the author published a book about the experiences of twenty-six American physicians who had recently graduated from medical school and were completing a postgraduate residency program in internal medicine. This book, which is being published more than thirty years later, is a continuation of that book's research project. In the years since that initial research, the author stayed in contact with most of the physicians whom the author first interviewed in the late 1970s, and for close to forty years the author have continued to interview and gather information about their experiences as physicians. The book presents the findings from this unique long-term study of these individuals, shining a light on their career-long medical experiences, while also revealing important information about the health care industry in America and how it affected their own professional lives and that of their counterparts. From the 1960s until the late second decade of the twenty-first century, the medical profession in America underwent many turbulent changes. The book looks closely at how the career satisfaction of these twenty physicians evolved over the course of these decades, particularly in relation to their patients, peers, and practice. This in-depth longitudinal study builds on the research the author conducted when these individuals were all in the same three-year internal medicine training program. It incorporates an additional five interviews the author conducted with them during each decade until they were at or near retirement in 2016.

2. ***Life Beyond Medicine***
   By: Sharon Romm (2019)
   - Recommended good practical advice: Focuses a lot on people "forced" to retire rather than choosing to do so.

3. ***Retirement and its Discontents***
   By: Michelle P. Silver (2018)
   - Not entirely devoted to physicians but does feature both academic doctors and PhD researchers. It is important to keep in mind that she interviewed MANY people, and this book is based only on those experiencing "discontent."

PODCASTS

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1. **"What Comes Next? A Physician's Retirement Story - with Dr. Bob Rosen", *Doctors Eyes Only,* ep. 11, June 30, 2021, 37 minutes.**
   - As a physician, the thought of retirement can be anxiety-inducing. You are used to working endless hours in your practice and then all that stops – what comes next? In this episode, Lauren Oschman and Kameron Helmuth are joined by retired emergency medicine physician, Dr. Bob Rosen, as they discuss Bob's journey into retirement.

2. **"Working Less is Worth Every Penny", *Optimal Finance Daily*, ep. 2047, September 29, 2022, 13 minutes.**
   - Episode 2047: Working Less is Worth Every Penny by Leif of Physician on Fire - Leif is a former anesthesiologist, a family man, and a supposed outdoors enthusiast who spends way too much time indoors. Physician on FIRE is a personal finance website he created to inform and inspire both physicians and our patients with insightful writing from a physician who has attained financial independence and the ability to retire early. The site has a triple aim to leave visitors enlightened, educated, and entertained.

3. **"An Alternative to Traditional Retirement: Considerations for Physicians", *Sound Practice*, January 27, 2021, 37 minutes.**
   - Most physicians follow or supplement their clinical practice with physician leadership roles, and wind down their careers by scaling back to part time executives or clinical consultants before official retirement. Richard Afable, MD, MPH, FACP, suggests an alternative. After retiring from CEO and executive roles at several large health systems, Dr. Afable now advocates for community wellbeing and the development of others as the President and Board Chair of BeWellOC in Orange County. In this episode, we interview Dr. Afable about how physicians can (and should) plan for a type of "third career" - one that focuses on significance and service. He also shares concepts that physicians can consider as they work towards a retirement plan.

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VOLUNTEER ACTIVITIES FOR RETIRED AND LATE CAREER PHYSICIANS

VOLUNTEER ACTIVITIES

1. **HELP: Health English Language Pro**
   Website: https://accesemployment.ca/programs/bridging-and-sector-specific-programs/help-program

   HELP is a volunteer organization with a unique focus to support foreign-trained physicians to gain fluency in pronunciation, acronyms and abbreviations specific to medicine. HELP creates one-to-one matches between volunteer physicians and foreign-trained physicians. HELP participants commit to meeting virtually for 12 sessions, approximately one hour per week over 12 to 16 weeks. HELP has developed a library of modules, case scenarios for role-play, and videos to use as springboards for conversations. Volunteer physicians can participate as frequently as they choose.

2. **Volunteer Toronto**
   Website: https://www.volunteertoronto.ca

   This is a charity that builds caring communities by connecting volunteers to the causes that need them. Their services empower local volunteers to find opportunities that make positive differences in their communities. Through in-person and online training, they help non-profit organizations and community groups run successful volunteer programs.

TRAVEL VLOGGERS AND WEBSITES

TRAVEL VLOGGERS

1. **Brian and Carrie Travels**
   Website: https://www.brianandcarrietravels.com/
   About: American couple who sold everything and are traveling full-time; fun escapism but also very practical info about costs of different countries for those who might want to spend some time abroad.

2. **Retirement Travelers**
   Website: https://www.retirementtravelers.com/
   YouTube Video: Retirement Truths: 6 Lesson Learned After Retirement

WEBSITES

1. **The Retirement Manifesto Blog**
   Link: https://www.theretirementmanifesto.com
   About: A retired blogger (not a physician) with many insights on retirement.

2. **Sigh Set on Retirement – Dr. Graham Trope**
   Link: https://www.uhn.ca/corporate/News/Pages/Sight_set_on_retirement.aspx
   About: Dr. Graham Trope retires from UHN and reflects on being ready to shift from "living at work" to "working at living" through his many personal passions and pursuits.

3. **Preparing for Retirement – Dr. Liesly Lee**
   Link: https://deptmedicine.utoronto.ca/news/preparing-retirement
   About: Dr. Liesly Lee highlighting the need for flexible, supported retirement planning that benefits both individuals and the broader academic mission.

4. **A Personal Perspective on the 'Big R' – Retirement – Professor Emerita Anne Kenshole**
   Link: https://deptmedicine.utoronto.ca/news/personal-perspective-big-r-retirement
   About: Professor Emerita Anne Kenshole shares personal insights and practical guidance on the Dos and Don'ts for transitioning to retirement, drawing from her own rich post-retirement experiences and offering a thoughtful roadmap for others considering the "Big R."

5. **Retirement: Highlights of a New Sunset - Professor Emeritus George Fantus**
   Link: https://deptmedicine.utoronto.ca/news/retirement-highlights-new-sunset
   About: Professor Emeritus George Fantus shares his diverse and personal retirement stories. Sharing stories of physicians who never fully stepped away, who embraced retirement with enthusiasm to underscoring that there is no one-size-fits-all path, and highlighting the need for flexible, individualized, and ethically grounded retirement planning in medicine.

6. **Looking Back: A Retirement Interview Series - University of British Columbia**
   Link: https://medicine.med.ubc.ca/newsannouncements/looking-back-a-retirement-interview-series/
   About: A series of interviews by the University of British Columbia that looks at the diverse and storied careers of faculty members in the Department of Medicine.

7. **Physician Retirement: How To Know When It's Time - Dr. Heidi Moawad**
   Link: https://www.wolterskluwer.com/en/expert-insights/physician-retirement-how-to-know-when-its-time
   About: Physician retirement can be a deeply personal decision influenced by financial readiness, identity, relationships, and post-retirement plans, requiring honest reflection, and open communication to navigate the emotional and practical challenges of leaving clinical practice. This article asks questions that you should think about before retirement.

8. **Lost in Transition? Thoughts on Retirement, Part 2. "Should I Stay or Should I Go Now?" (Commentary, The Oncologist)**
   Link: https://pmc.ncbi.nlm.nih.gov/articles/PMC8342569/pdf/ONCO-26-e1290.pdf

9. **Reinvention or Being Carried Out in a Box: Non-Financial Aspects of Physician Retirement (Handout, Presentation at AGM of the Society of Teachers of Family Medicine)**
   Link: https://urldefense.com/v3/__https:/resourcelibrary.stfm.org/resourcelibrary/viewdocument/non-financial-aspects-of-physician__;!!FxkXuJIC!Y8an2ZQg7dyL-KXSdC_uJvya-8EFNVd0mxxjRM3ZQALOw0DdYokdc83YQp6sPfvnDmmEpR0PHu4aB4P09911-Yywh6k$

10. **Retirement Readiness Tool - Doctors Manitoba**
    Link: https://doctorsmanitoba.ca/career-resources/career-transitions/retired-doctors/retirement-practice-closure/retirement/retirement-readiness-tool
    About: A readiness tool designed by Doctors Manitoba designed to assist you in planning for retirement

CLOSING YOUR PRACTICE CHECKLISTS & REQUIREMENTS

HELPFUL LINKS

1. **Canadian Medical Protective Association**
   Helpful tips for physicians who are closing and leaving a practice and outlines when you need and don't need CMPA coverage and when/how to notify CMPA during practice interruptions and end of membership.
   Link #1: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2020/closing-or-leaving-a-practice-tips-for-physicians
   Link #2: https://www.cmpa-acpm.ca/en/membership/interrupt-or-end-membership

2. **College Of Physicians and Surgeons of Ontario**
   Two documents that outline college requirements of the MD to ensure/facilitate ongoing patient care, communication to patients, notification to College re: 'resigning' from membership
   Last updated 2019.
   Link #1: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Closing-a-Medical-Practice
   Link #2: https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Closing-a-Medical-Practice/Advice-the-Profession-Closing-a-Medical-Practice

3. **Doctor Care**
   A health care consulting service that provides a retirement action plan checklist to support physician transition planning; practical patient, financial, legal, communication tips. Published in 2021
   Link: https://www.doctorcare.ca/wp-content/uploads/2021/03/DoctorCare-Toolkit-Retirement-Checklist-20181116.pdf

4. **HealthForceOntario**
   Offers a 'Transition Out of Practice service' (ToPS) module, Community-based MD perspective, outlines steps to finding an MD replacement, logistics of transferring/closing a practice
   Provides tools, a checklist, a template and resource links. Last updated in 2019.

   Link: https://www.healthforceontario.ca/UserFiles/file/ToPS/TransitionOutOfPractice-en.pdf

5. **Ontario Medical Association**
   Provides top 20 FAQs (from Ontario Medical Review) re: practice closure/transfer logistics and a link to 'Closing A Practice: A Guide for Physicians" – outlines logistics and legal/professional obligations in closing a practice: planning, business, patient and association obligations. Published in December 2020.
   Link: https://www.oma.org/newsroom/ontario-medical-review/archived-issues/87-5/closing-your-practice-due-to-retirement/?gad_source=1&gclid=CjwKCAjw1emzBhB8EiwAHwZZxeCu5DdZ7pSpoRnGqH1WHnHvtd_JzF0hvQGmGD6nBNWn0DB-T-YOXBoCxx8QAvD_BwE