Shifting Gears:

A Guidebook for Late Career Transitions and Retirement

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Temerty Medicine

Disclaimer

From the Temerty Faculty of Medicine

For those seeking support, this Guidebook provides a variety of options including online resources as well as connections to external third-party resources or to professionals offering therapy and other wellness advice. Please note that while many of the resources/applications/third party providers offer free services, others may direct you to programs or services that are fee-based. While we are providing links to resources we believe may be helpful, these links are being provided as a convenience and the Temerty Faculty of Medicine does not endorse, and we are not responsible for, any content, products, services or other materials on or available from such third-party applications/websites. We encourage you to ensure you review the terms of any third-party programs or services, including any fee-based resources or programs.

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01
Preface

Written by TFoM physicians, for TFoM physicians.

Shifting Gears: A Guidebook for Late Career Transitions and Retirement is written by TFoM physicians, for TFoM physicians. However, over the course of preparing this guidebook, it has become abundantly clear that this resource could be useful for physicians across Canada.

It is intended to address commonly raised questions and concerns among physicians regarding the stages of transitioning toward retirement, as well as the retirement process itself.

We will be reviewing an adapted model based upon the Stages of Change, first proposed by Prochaska, to closely align with the physician career trajectory (*Figure 1* ▸). We hope this provides you with a framework to think about your own path, and helps to identify what stage you find yourself at any given time.

This guidebook does not attempt to answer all questions. There are many resources available for specific issues and we have provided a companion reference list to assist you with additional relevant materials. While every physician will have their own unique career path and timeline, we will address some of the common themes that resonate with many of us.

Throughout, we offer shared experiences, findings from the literature, and suggestions for action. Certainly not everything will resonate or be relevant to you. However, in addition to providing information and guidance, we hope that this guidebook stimulates discussion, enables us to reflect more intentionally about our career decisions, assists with career planning and offers a sense of community and support for physicians at Temerty Faculty of Medicine.

This guidebook addresses common physician questions and concerns regarding the stages of transitioning toward retirement and the retirement process.

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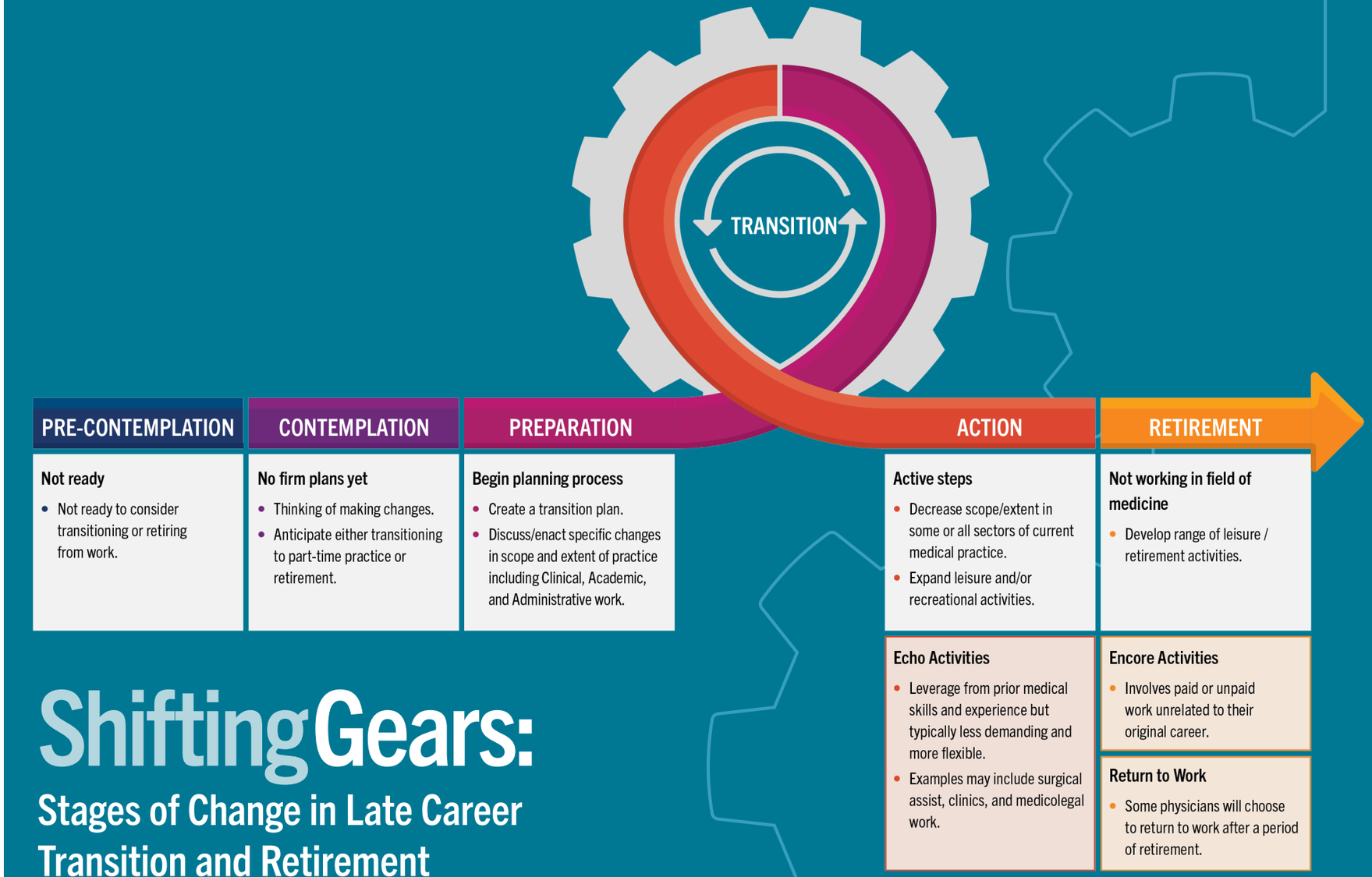
Stages of Change Model

This diagram was designed for later career physicians to reflect on their current stage of late career transitioning to retirement.

Figure 1. Stages of Change in Late Career Transition and Retirement

We recognize that although the diagram is linear, the process is not. During a physician's late career there are some "shifting gears" where you can move back and forth especially in the middle stages; this is determined by clinical practice issues, wellness, finances, institutional issues including practice plans, and social circumstances.



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The Many Faces of Wellness

The following is a Guide to the Many Faces of Wellness for you to consider in your late career journey.

Introduction

Are you looking forward to slowing down, taking more time off and making some important decisions regarding the last part of your career while you transition to your retirement? Many of us love what we do each day at work — the challenges of problem solving, the pride we have in our contributions to our community and the feelings of accomplishment at the end of the day; we enjoy the company of our professional teams who in many cases feel almost like family; even if our finances are secure, we may continue to work in late career because we love it.

At the same time, many of us are challenged by our current work environments. More than 50% of us have experienced burnout symptoms during Covid and post-Covid.[1] As we age, we also may be more vulnerable to burnout as our cognitive and general health is challenged by the impact of acute and chronic medical illnesses, illness in our partner/spouse, financial challenges, losses of loved ones and the impact of adapting to rapidly challenging technologies.

There is very good evidence that the level of our expertise to practice medicine gradually wanes as we move into our 70's and 80's.[2] There are age-related changes including cognitive abilities like memory, processing speed, visual acuity, physical stamina all of which can impact our ability to function as physicians. Fortunately, many of us can maintain high levels of competence via practice management (slowing down, restricting our practice to focused areas, and continuing professional development).[3]

50%

Of physicians have experienced burnout symptoms.

Understanding your vulnerability to burnout and the age-related changes can contribute to feeling uncertain and anxious about making changes in your practice. It is crucial to listen to your body to help preserve your wellness over time. There is significant literature to support the notion that ***wellness*** is a key determining factor to a happy and fulfilling career transition and retirement.

Exercise

The importance of regular exercise throughout one's career is important for general health and in particular preserving brain health.[4] We know physical activity can energize you, impact your mood and combat fatigue and burnout. Many of us have routines that we can continue and adjust as we age. We recognize that aging requires a more targeted approach to our physical well-being. Two key areas to target are maintaining muscle mass and mobility, these can be accomplished with the addition of resistance training (e.g. weights) or multifocus programs directed at strength, mobility and balance (e.g. Tai Chi). These activities may help reduce sarcopenia (loss of muscle mass) and osteopenia (loss of bone density).

For those of you who have not started to exercise, getting started may be the most challenging part. Getting an exercise buddy to go swimming or to the gym can be helpful. Hiring a trainer can provide you with a structured program of exercise (and support) that many of us need to get started. Once we are able to complete a supervised program of exercise, it can provide the structure to repeat several times a week. Incorporating workout routines during the week is a good psychological reminder that our health comes first.

Wellness is key to a happy and fulfilling career transition and retirement.

Physical activity can energize you, impact your mood and combat fatigue and burnout.

Tips to Get Started

- Start small and build gradually.
- Add resistance training 2–3 times per week to maintain muscle and bone health.
- Try balance and mobility routines like Tai Chi or yoga.
- Consider a trainer or workout buddy for structure and accountability.

Nutritional Health

We are what we eat. There are some basic guidelines in managing our diet in later life. Focus on optimizing intake of healthy whole foods by incorporating plant-based and lean protein sources, minimizing processed foods, and selecting supplements that align with current health status. Working with a nutritionist could be a helpful way to begin supporting these dietary choices and tailoring them to individual needs. Cooking and eating with others can foster enjoyment and connections with friends and family. Concepts relating to nutritional supplements, metabolic dysfunction and the treatment of pre-diabetes are undergoing rapid evolution in evidence-based medicine. Monitoring these areas as we age may be important to maintaining healthy physical and brain longevity.

Nutritionists also emphasize nutrient-dense foods, including lean protein such as chicken, fish, legumes, eggs, and low-fat dairy products. Whole grains, vegetables, fruit, adequate fibre, calcium, Vitamin D, Vitamin B12, and potassium are also recommended. In addition, reducing sodium, sugar, and saturated fats helps manage age-related changes like muscle (sarcopenia), bone density (osteoporosis) loss, and heart disease. Omega-3 fatty acids, found in fatty fish like salmon, mackerel, and sardines, as well as flaxseeds and walnuts, are excellent for heart and brain health.

For women in particular, the onset of menopause may be associated with progressive decrease in bone density. Monitoring bone density and ensuring adequate calcium or appropriate replacements is strongly recommended. Resistance training may be helpful in maintaining or improving bone density.

Health Canada recommends water as the beverage of choice to support health and promote hydration without adding calories to the diet.[5] The new recommendations from the Canadian Centre on Substance Use and Addiction (CCSA) advises reducing alcohol use to the point where no amount of alcohol is considered safe.[6] Specifically, they suggest limiting consumption to no more than two standard drinks per week for both men and women. This will in turn reduce the risk of several types of cancer, heart disease, stroke and liver disease.

This is an area of health that continues to evolve. It is important to find a reliable source of nutritional needs for healthy aging.

We are what we eat

- Focus on whole, nutrient-dense foods
- Balance plant-based foods + lean proteins
- Limit processed foods
- Work with a nutritionist for personalised guidance

Hydration

- Water: Best choice
- Limit Alcohol: ≤ 2 drinks/week

Key nutrients

- Fibre
- Calcium
- Vitamin D & B12
- Potassium
- Omega-3 fatty acids

Sleep Health

Late career physicians may still be taking calls and working long hours. As we age we sleep less at night with more frequent awakenings and experience less of the reparative Stage 3 (N3 or deep sleep) and Stage 4 (REM sleep) cycles. We can partially compensate by improving our sleep hygiene with simple techniques such as eliminating caffeinated beverages after 6 p.m., going to bed earlier and removing electronic devices from the bedroom. It is recommended that we have 7–8 hours of uninterrupted sleep each night and that we go to bed and wake at the same time each day.

Sleep disorders are under-diagnosed. 20% of adults have a sleep disorder: obstructive sleep apnea (OSA) increases as you age and 80% with OSA are not diagnosed.[7] This will impact stamina, resilience and emotional health. Feeling tired every day, falling asleep while watching TV despite spending 8 hours in bed at night are warning signs that a sleep disorder assessment is indicated.

Given the normal changes in sleep physiology, negotiating with your Chief and/or Division Head for reduced or no overnight call after the age of 60 is something some Departments have initiated but may not feasible in all Departments. Incorporating decreasing call requirements at different age thresholds may provide an impartial mechanism of reducing call within groups. Creative solutions such as older surgeons offering or selling their “on-call” to younger surgeons has been tried in some jurisdictions as a means of addressing the normal changes in energy that occurs as one ages and to help prevent burnout. In many groups, particularly non-surgical groups, it is increasingly difficult to find someone who is willing to take your call under any conditions. Although many older physicians still enjoy and tolerate the on-call experience; providing flexibility in the on-call choices that are available to older physicians is optimal.

Healthy Sleep Habits

- Aim for 7–8 hours of uninterrupted sleep each night.
- Maintain a consistent sleep schedule.

Cognitive/Brain Health

Staying mentally active in retirement helps to maintain brain health.[8] Brain fitness is a developing field of interest that can boost the power, clarity and focus of our cognitive functions. We know that brain plasticity continues to grow as we age and that experience modifies brain structures into very old age. Engaging in new learning experiences boosts the development of the brain and ultimately improves information processing and information storage.

Many do not know where to begin and feel lost in the possible choices. Where does a physician find a volunteer role that fits their interests, is appealing and appropriately challenging and provides a substitute source of belonging to a community? Often, you need to work hard at pursuing or learning something new but this is often a very good prescription for maintaining your brain health.

As we age, there are normal changes that occur in our abilities to recall names and increased forgetfulness. We can compensate for these changes with some ease and usually these changes do not impact our competence to practice.

Along a spectrum of brain changes in older age, is mild cognitive impairment or MCI. This state is sometimes hard to distinguish from normal aging changes and includes forgetting things, missing appointments, losing your train of thought or having trouble remembering the plot of books that you leave for a few days, increasing difficulty finding the right words, difficulty with following instructions, briefly losing your sense of direction and poor judgement with some decisions. These symptoms may not concern you as we tend to normalize their significance. It is often your family or colleagues and even your patients who begin to notice these changes. Part of brain health then is staying reflective of any of these above changes that you notice and asking your partner or family/colleagues for their insights and observations.

Physicians can often compensate for the above changes in practice but not always. Having a frank discussion about the implications of these changes with your physician and family members can optimize a healthy accommodation or exit from practice.

Self-Care

We know that physicians often struggle with self care, sometimes delaying medical attention even when there are symptoms that are serious. Medical culture can discourage physicians from acknowledging their own vulnerabilities and seeking help, sometimes leading to a belief that they should be able to self-treat or that seeking care is a sign of weakness. Studies show that physicians frequently self-treat minor conditions and may even self-medicate for chronic illnesses. Physicians express concerns about confidentiality, and difficulty accepting the patient role.

In residency training physicians learn about the relationship between professionalism and the need to prioritize their own health. This is not always practiced in late career. The old adage “physician heal thyself” should be interpreted to mean we should take care of ourselves and make use of all of our available resources. Many organizations including the OMA Physician Health program offer confidential physician mental and physical health care including counseling and support programs.[9]

Mental and Emotional Well-being

Navigating the psychological impact of cutting back your work, dealing with feelings of guilt when you give up your practice, experiencing feelings of loss of identity, managing health challenges and feeling anxious about the future can be challenging. Changing your work schedule when your practice has not changed much in 30 years, can be surprisingly stressful. There is a certain amount of emotional work that is involved in late career transitioning that can take its toll on our mental health. Physicians will often cope with this uncertainty by talking with colleagues who are navigating similar issues, gradually replacing full time work with part time, taking longer vacations, adding creative activities such as writing, and other artistic pursuits or begin volunteer activities.

The first year of retirement is often the most uncertain. A helpful psychological strategy to approach this is to re-frame this as your "retirement gap year". This is a year to experiment with structuring your day with meaningful activities and to explore your interests. Often this includes regular exercise and taking up new creative and volunteer activities are common. Activities are tried and dropped — sometimes gleefully because you can! Having control of these decisions can feel liberating. Some physicians will maintain their license after retirement during this gap year, leaving them the option of returning to practice, full or more often part-time.

The burden for decision making can be lessened by congregating with colleagues of similar or older age to discuss your plans at whatever stage you are in. Joining our late career transitions group (community of practice) that was recently initiated in TFoM or a similar group in your Department is another opportunity for you to share experiences, challenges and tips. When you have retired from clinical practice, finding solace and support from colleagues who have also recently retired can be both reassuring and therapeutic.

Mindfulness and Meditation

Practices like mindfulness meditation can be learned at any age and applied both at work and at home to reduce stress, improve focus and capacity for reflection and improve mental clarity. Again, getting started with something new can be challenging; rest assured, the methods are surprisingly easy to learn.[10]

Individuals with close, supportive relationships tend to be happier, healthier, and live longer than those with fewer connections to people.

Relationship Wellness — Social Connections and Support Systems

The Harvard Study of Adult Development has consistently shown that strong, positive relationships are a key predictor of long-term happiness and well-being. Individuals with close, supportive relationships tend to be happier, healthier, and live longer than those with fewer connections to people.[11]

One of the challenges physicians tell us is the impact of retiring on their social connections. There is some evidence that for many physicians, their closest and most meaningful relationships are their work relationships. Physicians may worry about being lonely in retirement and this concern can delay the career transitioning and retirement process. It can be helpful to recognize that you are not alone in looking for community at this stage.

Multiple studies have found that loneliness and social isolation in older adults is associated with an increased risk of premature death, heart disease, depression, and cognitive decline. At the same time, rich social connections are associated with improved longevity and better physical and mental well-being.

Cultivating your social ties outside of work at any age can provide solace, support and understanding and a broader sense of community that can help normalize the experience of retirement. Having close friends also provides opportunities for the give and take of being helped when needed by others and of assisting others in their time of need. This provides a preventative strategy for mitigating loneliness in retirement.

Connecting with other similarly aged physicians who are also contemplating career transitioning and retirement can more particularly contribute to wellness through comparing notes, strategies and experiences.

Travelling for pleasure rather than work is something to be cultivated throughout one's career but is especially recommended in retirement. Exposure to other cultures, and the stimulation of novel vacation experiences adds new perspectives on life and enriches the diversity of relationships. There is also strong evidence that pets, particularly dogs and cats, have a positive impact on mental health and retirement, offering companionship, reduction of anxiety, and a sense of purpose.

Coaching, Counselling and Seeking Therapy

Some of us may benefit from more individual help with the transitioning process and with the prospect of retirement. There can be acute experiences of loss of your job, your identity and your steady income, fears of loneliness and having nothing to do in retirement. Professional services are available in Toronto including career counsellors, and psychologists and psychiatrist coaches who are focused on assisting physicians and others with the transitioning process. There is a "play within a play" at work here. Many of these coaches are older and are transitioning too; coaching physicians has become their echo activity.

Some of you will decide to both transition your career and/or retire because of burnout symptoms and/or a recurrence of chronic mental health issues that emerge because of the stress of practice, fears of retirement and diminishing energy and vitality. Returning to your psychiatrist/psychologist at this time can help prevent relapse and manage the acute symptoms.

Pursuing Creative Outlets and Personal Development

It is never too late to develop other interests outside of medicine and academia. Many physicians have cultivated diverse interests in the arts, recreation, sports and volunteerism that has helped maintain a balanced life throughout their career. Retirement also provides opportunities to return to interests and hobbies that may have been dormant for some time. Setting personal goals such as learning a new skill can provide a sense of motivation and accomplishment. Examples include learning how to play a musical instrument, learning to paint and other activities such as cooking and carpentry that can foster a sense of joy and discovery.

Having worked in the helping professions can facilitate a smooth transition to volunteer roles in retirement. There are many organizations that can benefit from the background of a physician.[12]

Sometimes there is a challenge in transitioning from our role as a physician where we function as a team or hospital leader to a role as a volunteer where your role may be "one of many". When you retire there is often a sense of freedom and liberation and obligations are much less urgent. Many physicians experience a renewed sense of control over their schedule that they have not felt since their teens. Physicians who spent time at summer camp in their youth can experience retirement as a recapitulation of that experience with scheduled time for fitness, reflection, travelling, volunteering, and creative activities. Spending time as you see fit can feel like a just reward for all the sacrifices and hard work as a physician.

Spiritual and Reflective Health

Retirement can be a time to deepen spiritual connections through meditation, prayer, or community involvement in spiritual groups. Reflecting on your career through journal writing or other forms of self-reflection can contribute to a sense of completion and closure. Some physicians will write a memoir or book as a means of passing on the wisdom of completing a career in medicine to the next generation.

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Identity

In this section, we will review some of the potential impacts you might experience related to your sense of identity, as you move through the stages of career change as previously outlined in this guidebook. We will include some possible planning preparations/ actions to consider.

Potential Challenges

It is quite common for our identity as a physician to represent a significant part of our core self identity. For some, becoming a physician is experienced as a calling, not simply a career choice. As Sadavoy has described:

"...being a doctor represents a deeply held and intrinsic sense of identity related to self-worth, contribution to the community, intellectual stimulation, and therapeutic and professional relationships, all placed at risk by aging." [13]

The intensity of the drive to be a physician and the intertwined nature of our professional and personal selves are often underestimated. Thus, it is not surprising that the transition in late career to retirement can present a number of challenges related to how we feel and think about ourselves.

The following sub-section briefly outlines these key challenges, taken from the literature[14] and from conversations with colleagues. Career transitioning is a very personal process; some of the following issues may, or may not, resonate with you. By no means are all retirement experiences difficult; many are very positive and enriching — for most of us, there will be a combination of highlights and challenges. Hearing from others may help you to focus on what fits with your experience as you move through the career transitions. The following are common themes among physicians as we consider/approach late career transitions.

> ***Being a doctor represents a deeply held and intrinsic sense of identity related to self-worth, contribution to the community, intellectual stimulation, and therapeutic and professional relationships, all placed at risk by aging.***
>
> ***Joel Sadavoy,*** *MD. FRCPc FCPA*
> Professor, Department of Psychiatry
> University of Toronto

Self-Concept

For some, the high work demands throughout our career may lead to less attention being given to other aspects of one's life, resulting in an imbalance between our professional and personal selves. Reimagining oneself, along with re-envisioning or reprioritizing life activities, will now require attention.

Self-Worth

The contributions we make through our work and professional lives are often closely linked to our self-esteem and self-worth. When we feel that we are contributing less as we wind down our careers, we may begin to question our self-worth.

Loss of Community

Another common experience in retirement is the loss of our professional community. For some, our medical workplaces have provided us with an important sense of belonging — some of our most meaningful relationships have developed within our workplace communities. We haven't had as much time to spend cultivating relationships outside of our professional lives and this can result in feelings of loss and isolation when we are no longer involved with our work colleagues.

Practice Legacy

For many of us, there is no control over who will continue our work, or provide service to our patients, once we stop clinical practice — this will be determined by Chiefs, Chairs and senior partners. For some, our area of practice is unique or underserved and it may be challenging to find a replacement. This may cause significant worry for you, for your patients' ongoing care and for areas of accomplishment that may lose traction or priority without you.

Institutional Response

A significant concern that many have expressed is a lack of institutional support as we approach the later stages of our career. Aging physicians are often not recognized and/or undervalued. Some have encountered significant biases from their administration when it becomes known that they are considering retirement or gradual winding down of clinical/administrative duties. Many hospital chiefs and departmental chairs are very supportive of physicians in their late career transitioning, but others may fail to provide the direction or support that is needed. In some circumstances, more overt negativity is expressed. Sharing our intentions may run the risk of being excluded from opportunities prematurely. Some feel 'forced' into a reduction of work responsibilities, and the timing of one's appointment ending is determined by others.

Competency

A fear of changes in our professional competency, particularly our cognitive and clinical skills, is one shared by many of us. We are required to perform at a very high level of competence, and confidence. As we age, we may begin to experience uncertainty about our level of competence. It can be unclear what the appropriate timing is to reduce clinical practice. Some of us may have less awareness of changes in competence and choose to work longer than ideal — this can lead to difficulties with administration, reduced patient safety and distressing conflicts/complaints/CPSO inquiries. This issue is addressed more fully in the *Wellness* ▸ and *Competence* ▸ sections of this guidebook.

Life Events

And of course, we need to be prepared to expect the unexpected. As Allen Saunders famously wrote (popularized by John Lennon) "life is what happens to us when we're busy making plans". Unexpected losses and life events, a death of a spouse, personal health changes to ourselves or significant others may completely change our trajectory, requiring re-thinking of our priorities.

While not an exhaustive list, the issues listed above are the common themes associated with identity in career transitions. Taking time to reflect on where you see yourself in relation to these ideas and your current career stage will contribute to your planning and actions moving forward.

> ***Life is what happens to us when we're busy making plans.***
>
> ***Allen Saunders***

What Can I Do?

In the following sub-section we offer some things to consider to help address some of the identity related challenges in retirement.

Ideally, awareness of potential issues and planning starts early, in the pre-contemplation phase. It has been suggested that we should begin developing a “diversified portfolio of ourselves” in the early stages of our career, when our identity is more malleable[14] — when we are potentially more flexible in how we view ourselves. But, even at a later stage in our career, it is not too late to begin to "diversify" our identity, beyond that of “physician”.

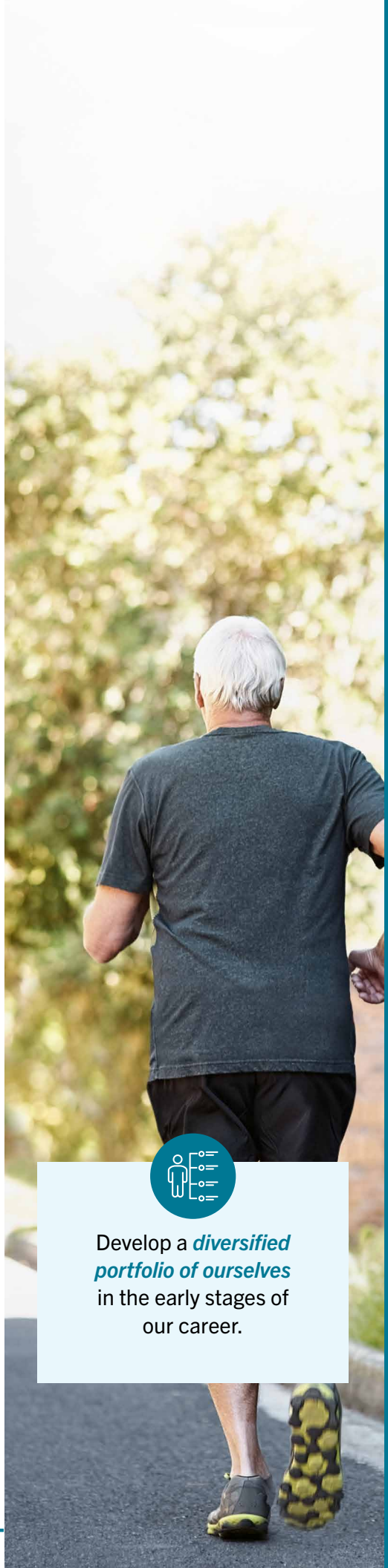
We can plan/initiate activities and relationships outside of medicine, but we can't predict which will become meaningful over time. Staying open to new experiences and opportunities may become an invaluable part of future retirement experiences.

Take time to initiate conversations with your partner/spouse and other significant relationships. This career transition will impact them too and it will be helpful to overtly think about what will change in the relationship — time together, shared activities, individual and separate needs.

While we are used to carrying a significant level of responsibility independently, and rely on our own judgement and skill sets, this time in our career is one that will benefit from expanding our “personal community”. It is a time to be intentional — to develop and cultivate friendships, supportive relationships, and possibly explore counselling or other formalized support. By expanding our “repertoire” of people and activities in our lives, we will be better equipped to face the unexpected as we move forward.

In preparation for discussions with senior administration, it may be helpful to identify “safe” colleagues to speak with when considering how to approach your Chair or Chief. Plan what you can ahead of your conversation with your senior admin and develop strategies to manage that which you cannot plan. Prior to the initial meeting, explore departmental and university policies and inform yourself about what you are entitled to and consider your own expectations. What are your priorities and what is realistic? Talk to colleagues who have previous experience with this transition re: what you might be able to negotiate. The *Practical Bucket List* ▸ section of this guidebook provides more detailed suggestions to consider.

It is sometimes helpful to seek the assistance of a life coach during our preparation phase — enabling us to reflect on these changes more fully. The *Wellness* ▸ section of this guidebook provides more information about this option.



Develop a ***diversified portfolio of ourselves*** in the early stages of our career.

05

Competence

Competence in a physician is expected by patients and colleagues, and practice which is below the accepted standard poses a patient safety risk, as well as placing the physician and the hospital/health care facility at risk for medicolegal action.

Introduction

One of the "elephants in the room" during discussions of a transition from active clinical practice is the issue of competence. The discussion requires both an understanding of competence within a given specialty and an awareness of potential political implications. It is well accepted that every physician should and must maintain competence throughout their career, but it is particularly important to be aware of this issue as one advances toward the later stages of practice.

There is extensive literature dealing with the effects of aging on cognitive function, hearing, eyesight, eye-hand coordination, fine motor skills, reflexes, stamina, and other factors that influence competence in a physician.[15] The age at which these things decline varies significantly from person to person, but there is no doubt that over time all of us will lose our ability to function at the highest level.[16] As a result of this, many occupations such as the airline industry have instituted mandatory retirement ages or compulsory testing programs in order to protect the public by ensuring competence. This kind of approach has not been instituted, and in fact is rarely discussed, in the medical field, which puts the responsibility for ensuring competence onto the shoulders of the individual physician.

In his book "From Strength to Strength", Arthur C. Brooks presents a paradigm (originally described by Raymond Cattell and Donald Hebb) in which we all have two types of intelligence.[17] The first is termed *fluid intelligence*, defined as "the ability to reason, think flexibly, and solve novel problems".

There is no doubt that over time all of us will lose our ability to function at the highest level.

This is the intelligence we see in young physicians that promotes innovation, creativity, and the building of a clinical and academic career. The second is termed *crystalized intelligence*, defined as "the ability to use a stock of knowledge learned in the past". This is the intelligence we see in older physicians that promotes wisdom, experience, and judgement, skills that are ideal for teaching and mentoring the younger generation of physicians.

Fluid intelligence develops early but then declines at some point, while crystalized intelligence continues to develop throughout one's career but may decline if the physician does not continue to update their knowledge and skills. There is also evidence that individuals showing greater losses in fluid abilities tend to show smaller gains, or even losses, in crystallized abilities.[18] Brooks makes the argument that successful transition from practice involves jumping from the fluid curve to the crystalized curve in a timely fashion.

Assessment of Competence in Physicians

Most of the literature involving assessment of competence in physicians has focused on achieving and ensuring competence in medical students and trainees prior to certification and licensure to practice. This takes the form of multiple-choice exams to test basic knowledge, OSCE sessions, and requirements to document continuing education activities with no process to formally examine competence. There has also been very little written about assessing competence in physicians who are late in their career, in whom the risk of declining abilities is highest.

Because there are no evidence-based or politically correct methodologies for assessing competence in late-career physicians, it is ultimately up to individual physicians and hospitals to be aware of the risks associated with declining competence.[19] What is also challenging for physicians is that as our competence in particular domains of practice declines we also have less ability to recognize this.[20]

What follows are some suggestions as to how this issue could be managed during the course of a physician's career.

01 PRE-CONTEMPLATION

This is the stage that we are in during our training and early in our career. Interestingly, the measurement of competence is an integral part of the training and evaluation process, even more so in the era of Competency by Design (CBD). As mentioned above, there has been a great deal of research into the best ways to evaluate competence in trainees, both cognitive and technical, so most residents and fellows get frequent feedback and can make adjustments based on that feedback.[21] However, once a physician goes into practice there is no longer a clear or consistent mechanism for providing that feedback, and it is up to the individual physician to ask for it. This can take the form of formal or informal mentorship relationships with senior physicians, regularly scheduled performance reviews, or more informal 360-degree feedback from colleagues, division chiefs, and trainees.

02 CONTEMPLATION

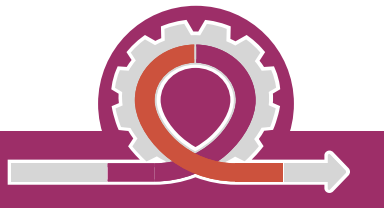
For most people, thoughts of retirement don't start appearing until they are in their fifties. However, issues that may affect competence often start before that. These may include physical conditions such as arthritis, diabetes, back pain, visual or hearing problems, etc, or mental health issues such as burnout, depression, or substance abuse. It is incumbent upon each physician to practice preventive physical and mental health care for themselves in collaboration with a primary health care provider, something that many physicians fail to do.

Continuation of mentorship relationships with senior colleagues, regularly scheduled performance reviews, and 360-degree feedback, as described in the pre-contemplation stage, is very important in identifying impending competence issues that the physician may not be aware of. These assessments not only function to identify competence issues that may stimulate contemplation of transition from practice, but also to identify opportunities for improvement in patient care, interpersonal professional relationships, and collaborative team dynamics.

In addition to 360-degree evaluations, hospital department chiefs should include a discussion of end-of-career transition plans during annual reappointment conversations, and those conversations should include a discussion of competence.

For physicians who are concerned about impending competence issues, or for whom others have expressed such concern, there are programs available to more formally assess cognitive function, technical ability, and physical and mental health issues.[22] These assessments should be made available to physicians on a confidential basis so that they can make informed decisions going forward.

03 PREPARATION AND ACTION



There are many reasons why a physician will make a decision to change their practice. In some cases, it is because a competence issue has been identified either by the physician or by others. In these situations, a new path forward must be chosen which eliminates the risks posed by whatever factors have compromised the physician's competence. In some cases, the physician can still practice medicine in a different way that isn't compromised by whatever competence issue has been identified, and creative ways can be developed that permit the physician to have fulfilling echo activities. Of course, continued monitoring of ongoing competence must be maintained by the physician and by those with whom he/she is working. In other cases, the physician cannot continue to work in medicine because of the competence issue, and in these situations the physician must move into the retirement stage and develop other meaningful and fulfilling activities to transition into.

Often the Preparation and Action phases of transition are associated with a decrease in income, which may be problematic, particularly if the physician is relatively young. It is important, once a competence issue has been identified, to consider activating one's disability insurance coverage, as many conditions that result in a loss of competence will be covered and will provide much needed financial support.

06

Actions To Retire or "The Practical Bucket List"

"Winding up to wind down" with intentionality is an important process which should occupy a similar amount of time to early career planning.

Introduction

The planning process for retirement typically occurs over a 2–10 year period, hopefully with the same degree of focus and planning that your early career planning required. The knowledge that we may spend two decades or more in the retirement phase should act as an impetus to designing an optimal retirement. It is important to implement a positive mindset towards new challenges and opportunities in order to pivot successfully into retirement. The biggest challenges may be in defining your future identity, relationships and purposes, and to understanding your financial situation. The prospect of change and losing a deeply ingrained identity can be stressful and even terrifying, leading some to frame upcoming retirement as "losing their purpose" or "throwing it all away".

A clear acknowledgement of a physician's value (leaving a legacy) is an important psychological component of happiness in the process of retirement. For the retiring physician, it is important to plan how to meet our very human needs for structure, community and purpose, within a retired world.[23] Redeveloping hobbies, engaging in new hobbies and community and developing a new daily structure have all been shown to be of value in a successful retirement plan.

One of the most important components of a transition to retirement is the concept of "plan ahead". This permits one to successfully finish their career plans, close their business and put their finances in order.

Thinking of reducing your clinical workload or adopting more flexible hours can be a good place to start. Some physicians will delay or avoid this initial step due to concerns about a potential negative impact on their career. There may be concerns that you will no longer be considered as a front runner for administrative leadership roles once you begin the process of stepping back clinically. Having a frank and open discussion with your Chief can address these issues directly.

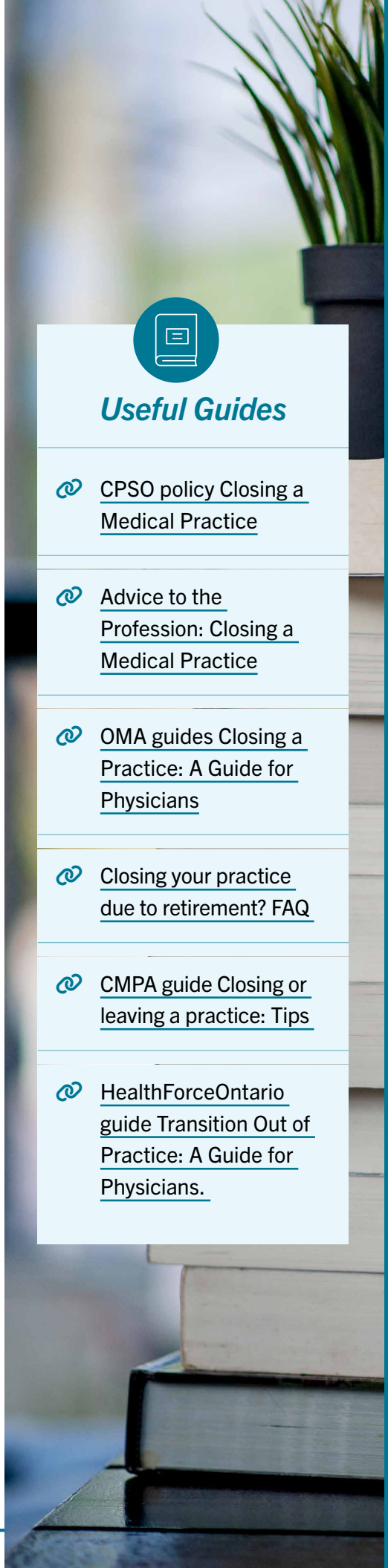
Providing an opportunity for a flexible phased retirement, can be of value to both parties. Practically, many departments limit flexibility and do not consider transitions to part time or reductions in "on-call" responsibilities, thus making these choices even more challenging.

Opportunities for a senior physician to remain available to the university is often underappreciated by the leadership and partners. An example of such an opportunity is when a senior physician transitioning to retirement or newly retired works as a "per diem" or locum physician. This can provide an innovative model for both the late career physician and their practice group. As a "per diem" or locum physician, the transitioning physician can offer increased flexibility to the practice group. This potential 10–20% additional coverage may permit increased academic time among the group, cover unexpected leaves or allow for increased patient care volumes.

In general, per diem physician coverage is fiscally advantageous to the group as benefits, such as vacation accrual, are not associated with this type of position. We recommend that developing a per diem program as a bridge to retirement may be a win-win situation and should be considered by department chiefs. Given the ongoing physician shortage and documented burnout in all communities of practice, making the most of the senior/newly retired physician should be a goal of physician leadership.[24]

Alternatively, other retiring physicians may prefer to reduce or eliminate any clinical load, administrative or research endeavors. The optimal setting is when both the administration and retiring physician can come to an accommodation which will benefit both the retiring senior physician and the group practice.

A well-planned retirement in theory will lead to a smoother transition for yourself, your colleagues, department and the university. There is no mandated age of retirement. For salaried faculty typically a 1-year notice is required either for retirement or to engage in the 3-year phased retirement program provided at the University of Toronto in some faculties. For non-salaried



Useful Guides

- CPSO policy Closing a Medical Practice
- Advice to the Profession: Closing a Medical Practice
- OMA guides Closing a Practice: A Guide for Physicians
- Closing your practice due to retirement? FAQ
- CMPA guide Closing or leaving a practice: Tips
- HealthForceOntario guide Transition Out of Practice: A Guide for Physicians.

physicians in private practice plans, the usual notice required by the university is a minimum of 6 months. According to the CPSO, the individual physician is ultimately responsible to organize their clinical practice succession in terms of patient referrals and follow-up. These arrangements may be supported in part or entirely by the department or hospital. Some TFoM hospitals have a specific policy that outlines the steps and responsibilities when a physician leaves clinical practice.

The heads of programs, departments and divisions at TFoM are encouraged to provide options for physicians in their transition from late career to retirement. Different hospitals and divisions will be at different stages in their ability to provide guidance and opportunities for gradual changes in practice that are beneficial to both the individual physician and their Department and Program. This guidebook is supported by TFoM and is an example of the leadership in the process of a cultural change in providing a safe environment for contemplation of transition to retirement and to celebrate the achievements of their career.

What Are My Potential Continued Associations with the Hospital and/or University?

A. Professor Emerita/Emeritus Status: What is it and how do I apply?

This is an honorific title bestowed on faculty members who have retired from TFoM. It is a recognition of their past and potentially continued substantive contributions to the university community. Typically this applies to faculty members who retire at the rank of full professor but may also apply to associate professors and/or part-time faculty who are considered to have made significant contributions. The approval process begins with a discussion with the appropriate physician in chief and notification to the University Department Chair in writing of the intent to retire and interest to apply for the title of Emerita. Subsequently the Department will prepare the application for submission to the academic human resources department.

An emerita status, in addition to the recognition of your value to the university, will also permit ongoing library access, tuition waivers including the scholarship program for dependents, computer and email access. It also includes membership in the Senior College (annual fees), an academic home for retired Faculty, Librarians and their spouses which provides activities such as lectures, a monthly book club, social activities and room booking possibilities. You can also continue to engage in a variety of teaching, mentorship, scholarly and leadership activities at the university.

A hospital appointment and CPSO registration are required to engage in clinical bedside teaching. A research institute/hospital appointment is required to engage in research supervision. A School of Graduate Studies appointment may be required depending on the type of learners.

Note: Policies, eligibility criteria, and benefits associated with emerita status vary by institution. Faculty members should refer to their own medical school's policies and administrative offices for institution-specific guidance. The description above reflects practices at the Temerty Faculty of Medicine (TFoM), University of Toronto, as an illustrative example.

B. Adjunct Clinical Faculty Member: What is it?

This is a university faculty appointment (not hospital based) which permits the physician to perform clinical, administrative and research activities or other negotiated activities. This position typically entails less than 20% time spent in academic activities.

C. Clinical Associate: What is it?

This is a temporary hospital appointment to provide patient service which is renewed on an annual basis. This is not a faculty appointment. Typically, this position is used to fill positions related to coverage for issues such as parental leaves, sabbaticals or increased volumes. Although teaching may be part of the job description, you will be unable to fill formal assessments such as an EPA (Entrustable Professional Activity) which requires a university faculty appointment.

Can I Maintain My Faculty Appointment Without Doing Clinical Work?

As a prequel to retirement, some physicians may wish to continue their faculty appointment remaining involved in research, administration, graduate supervision or creative professional activity (CPA). This is possible but the requirements may vary between departments, for example in the Department of Medical Imaging, 20% clinical activity is required to maintain a faculty appointment. This can be discussed with your University Chair and Department Chief and the decision to maintain your faculty appointment or move towards another status such as professor emerita can be considered.

I Have Retired From the University but I Still Want to Work. What Are My Options?

This is typically divided into the broad categories of echo or encore activities. These are distinct from the multitude of volunteer and charitable efforts that one may choose to be involved with. Charitable work may be based on your expertise, but in this context remains an unpaid or volunteer position.

Echo Activities

Echo activities is one which leverages your prior skills and experience within medicine but typically would be less demanding and more flexible. Some physicians may choose less closely affiliated areas such as regional or national politics relating to the health sector. This form of incremental withdrawal can assist with managing the impact on our personal emotional health and identity. Many examples are provided in *Table 1*.

One area to be aware of is the necessity to maintain CMPA membership if you want to maintain your license, even if you only perform administrative work. The relevant CMPA administrative only section is Work Code 20 described as “Administrative Medicine (Medical Executive or Advisor) — no clinical or patient contact, no prescriptions”.

For some specific examples and opportunities at Temerty Medicine, provincially and nationally, please refer to the *Opportunities for Late Career & Retiring Physicians* document created by Medical Affairs and the Physician Wellness Program at UHN.

Encore Activities

An encore activity is typically unrelated to your original work experience but differs from volunteer work in that you may or may not be fiscally compensated for the work you do. This may include areas such as authorship, business ventures, amongst a vast range of opportunities. For example, a physician may choose to work in politics, but unrelated to the health sector.

Exploring Post-Retirement Work Options

Echo Activities

Echo activities leverage your prior skills and experience within medicine but are typically less demanding and more flexible

Table 1: Echo Activities

Within the University

- Leadership positions in CME, faculty development, postgraduate education
- Teaching and mentorship for students, residents, fellows, and younger colleagues
- New or continuing scholarly and research activities
- Departmental or Faculty of Medicine committee chair or member

Note: Please check with your specific department as restrictions and opportunities may vary.

Within the Hospital

- Reduction in work volume / time
- Reduction or cessation of on call responsibilities
- Change in scope of practice
  - Cessation of surgery / procedures
  - Limiting to specialized area of practice
  - Clinics only
- Job-sharing
- Locum coverage within the hospital
- Development of patient education materials
- Teaching and mentorship for residents, fellows, and younger colleagues
- Development of CME (Continuing Medical Education) products
- Non-clinical hospital positions
  - Quality / safety improvement
  - Administration
  - Informatics
  - Global health initiatives
  - Equity, Diversity, Indigeneity, Inclusion, Accessibility (EDIIA) initiatives

External to the University or Hospital
Local/Provincial

- Clinical practice in community, locums, surgical assisting
- HealthForceOntario Physician Locum Programs (3 specialized programs)
  - Emergency Medicine
  - Northern Specialist
  - Rural Family Medicine
- Position with OHIP, OMA, WSIB, CPSO, Cancer Care Ontario, OMA committees or constituency groups, CPSO committee etc.
- Political work including public office, bylaws, engaging with public health administrators
- Health informatics system development
- Medical clinic ownership / management
- Education for affiliated companies, CME development, paid speaker bureaus
- Medico-legal work
  - Expert witness for CMPA, or out of country plaintiffs or defendants
  - Connect Experts
  - Med Counsel
  - MD Consultants
  - Consulting for other private companies
- Medical advisory board for pharmaceutical, medical device companies
- Other Boards of Directors
- Volunteer with health or non-health related organizations

External to the University or Hospital
National/International

- Journal editor or editorial board
- Global health work for Canadian indigenous or lower-middle income countries
- Position with CMA, CMPA, RCPSCS, CFPC, national / international professional specialty societies
  - Royal College Canada International Contracted Fellow
- Political work including public office, bylaws, engaging with public health administrators
- Health informatics system development
- Medical clinic ownership / management
- Education for affiliated companies, CME development, paid speaker bureaus
- Medico-legal work (see Local / Provincial)
- Medical advisory board for pharmaceutical, medical device companies
- REB Reviewer
- Entrepreneurial Networks
  - Bluedot
  - Health Innovation Hub
  - Physician Innovator
  - Society of Physician Entrepreneurs
- Other Boards of Directors
- University of Toronto Department of Family & Community Medicine
  - Rural Northern Initiative
  - Office-based family medicine locum opportunities
- OSCE Examiner
- RCPC International Development and Collaboration Grant Program
- RCPC Canadian Aid and Action Fund Grant

Professional Fees: What is the Status?

Physician Associations: Mandatory and Optional?

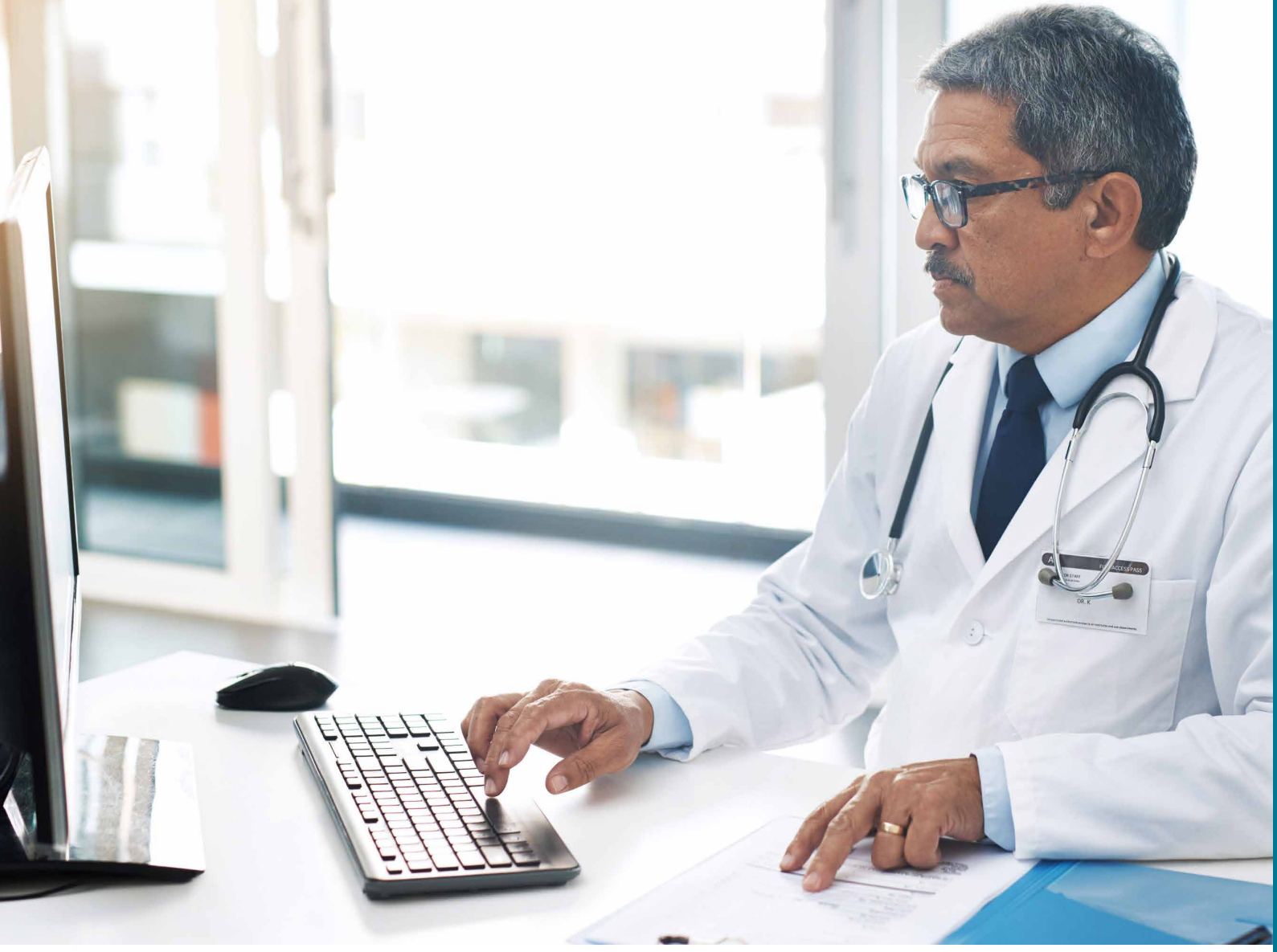
This is an evolving area which needs to be updated annually for specific details. It is often best to interact directly with the organization to include nuances of your situation, often not available as an online option. For example, the Royal College of Physicians and Surgeons of Canada fellowship designation will provide a reduction of 50% in annual fee if your net professional income is between $40–140,000 and a 75% reduction if it is less than $40,000 as of 2025.

Furthermore, the majority of professional local, national, international speciality organizations will reduce or eliminate fees for physicians who have reduced their practice or retired whilst permitting full membership benefits, thus it behooves the physician to inquire with each specific organization for individualized options.

Table 2: Fee Reductions Canadian Provincial and National Organizations

Organization	Reduction in Fee with Reduction in scope/ volume	Elimination of Fee with Full Retirement*	Additional Comments
CMPA	✓	✓	Review section on retention of fiscal, employee and patient medical records
CPSO	✓	✓	
OMA	✓	✓	Fee reduction with professional net income < $80,000 per annum. Retain membership with no fee in order to continue receiving OMA benefits and services.
RCPSC	✓	✓	Fee reductions with professional net income < $115,000 per annum. Maintain fellowship if fully retired.
CFPC	✓	✓	Fee reduction if < 20 hours per week.

**Typically defined as no longer carrying a licence or generating fees from clinical practice.*



CMPA Coverage: Additional Detail

It is important to inform the CMPA of any changes in your practice patterns. No CMPA coverage is required if you do not have an active license. If medical-legal difficulties arise from medical professional activities performed while your CMPA membership is active, you and your estate remain eligible for assistance.

For a clinic to be eligible for assistance, all physician owners must be CMPA members. If you are a physician owner (or part owner) and you retire from medical practice, you and any family members must dispose of all ownership shares/proprietary interest for the clinic to remain eligible for assistance. CMPA coverage should be maintained if you plan to do any medical work, including laboratory results reviews, access to medical records or prescribe medications. If you own/part owner of a clinic, you will wish to maintain membership in at least type of *work code 20* — Administrative medicine (Medical executive or advisor) — no prescriptions, no clinical or patient contact.

Helpful Tips and Links

The OMA has helpful *text and video* assistance for advice on closing your practice. Some key steps are outlined in the following Table.

Table 3:

Closing your Practice: A Suggested Timeline

2-10 yrs

Contemplation → Transition phase

Concept is that planning for retirement should require similar amount of energy and thought that early career planning required.

2-5 yrs

Contact professional advisors

Lawyers, accountant, insurance, real estate.

Formulate succession plan

Physician recruitment, transfer of patients.

9-12 mos

Review policies & contracts

Review medical storage policies, EMR contracts, inform providers of digital health

6 mos

Formal notification of retirement

Inform practice, administration, patients of intent to retire.

4-6 mos

Inform OHIP, MOH, colleges

Settle outstanding claims/queries minimum 3 months in advance. Minimum 6 months prior formal notice of impending retirement to administration and patients.

Inform professional associations

Consider adding an email addendum indicating that this address will no longer be active after [X] date and providing a new contact. For patient-related inquiries, ensure the new email meets HIPAA privacy requirements.

2-4 mos

Settle accounts

Settle accounts with tax, utilities, wind down suppliers

Equipment disposal

Dispose of medical equipment

1-2 mos

Dissolve MPC, close business accounts

Finalize loose ends.

Retirement

Patient records

Patient records must be retained for a minimum of 15 years (CMPA advice) or transferred to another physician. More specifically, adult medical records must be maintained for a minimum of 10 years after closing practice and children for 10 years after they attain 18 years of age.

Financial records

Retention of financial records for minimum 7 years (tax purposes) and of employee records for minimum 3 years.

07

Fiscal Considerations

Small regular savings early in your career can lead to significant income assets by the time you retire.

Introduction

If you have already retired, congratulations! If not, the time to start investing and saving for retirement is now. It is never too early to start saving based on the magical concept of compounding. Money invested, with a 7% return will double every 10 years. For example, if you put aside $1,000 at age 40 with the intent to retire at age 70 that $1,000 will have grown to $8,000. Alternatively, if you wait another 10 years till age 50, that money will have only grown to $4,000. The bottom line, the earlier you begin to save for retirement the more that money will compound or grow providing a larger nest egg when you do retire.

There are enormous differences between physicians with respect to net income, spending and saving styles. The average age of physician retirement is around 69 years. According to the 2025 MD Physician Retirement Readiness Study 49% of Canadian physicians are finding it hard to save for retirement.[25] Retirement may comprise a significant proportion of a life lived, thus planning ahead for a desirable lifestyle and goals of retirement will aid in decreasing anxiety about the transition.

The general plan of investing for retirement has two phases called the accumulation and the drawdown phase. In the accumulation phase registered accounts with tax deferred options like RRSPs, RFSAs and IPPS should be prioritized and maxed out. Some permanent life insurance policies have the potential for supplemental tax-sheltered growth. Risk is typically managed by diversification with periodic rebalancing as risk tolerance changes with differing stages of life. Rebalancing your portfolio on a regular basis will help account for these changes. This phase of life may require a pivot in your

49%

of Canadian physicians report challenges saving for retirement, according to the 2025 MD Physician Retirement Readiness Study.

approach to spending your assets rather than focusing on saving, depending on the amount you have accumulated. Psychologically this may be a challenging mindshift.

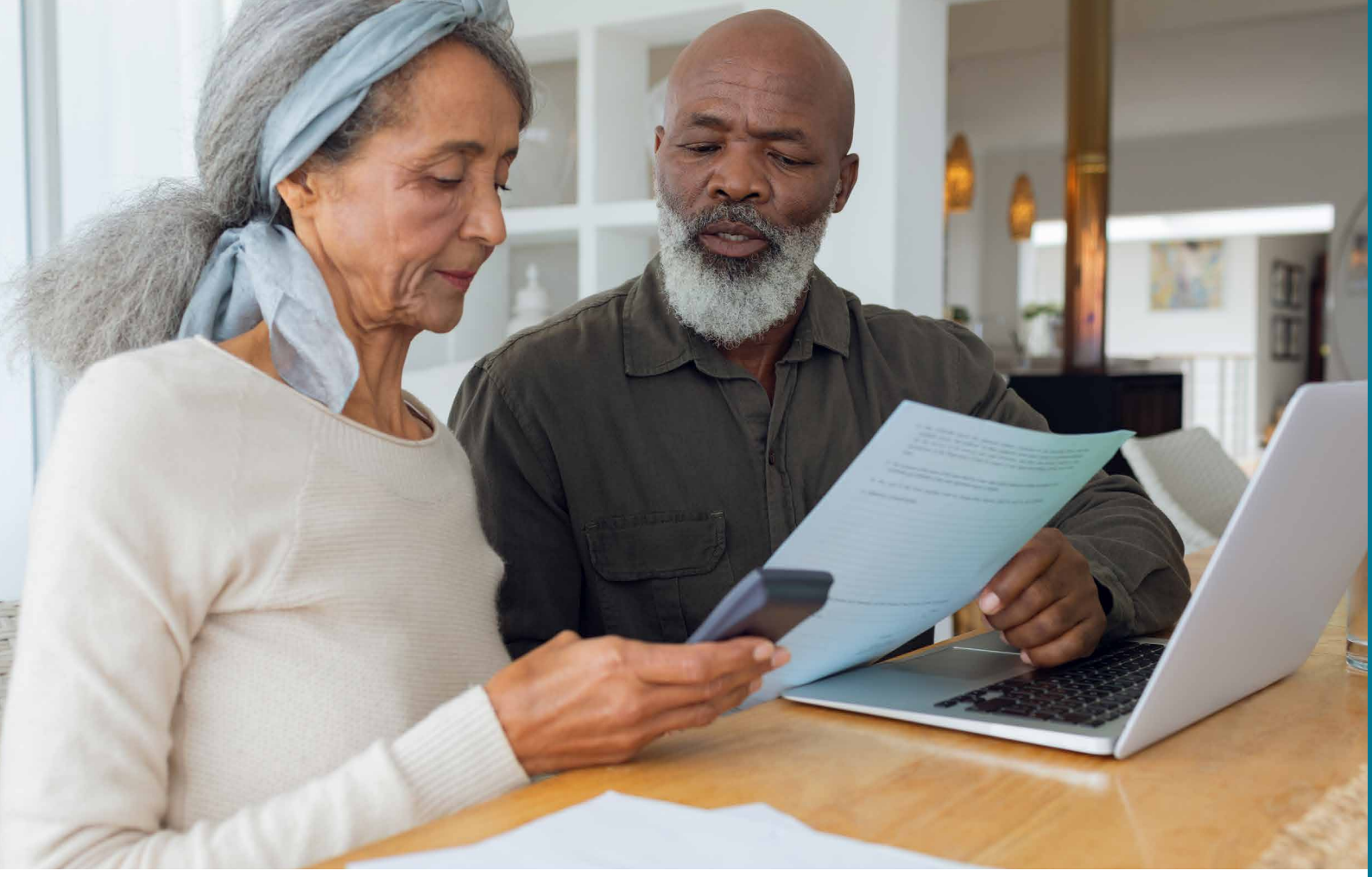
In medicine we believe we function best within teams, the same can be said about your financial planning efforts. In general, choosing advisors whose expertise is focused on doctors can optimize their advice. Your team may be entirely composed of specialists in areas such as financial planning, investing, tax and insurance law, or a combination depending on your own skill sets.

What Information Do I Need to Move Forward?

It is important to put together a "snapshot" of your assets and potential liabilities in order to better forecast how inflation and lifestyle changes may impact your financial future and whether adjustments are needed. (Table 4)

Table 4: The Financial "Snapshot"

Inventory of your Assets & Income Sources	+ Value of your incorporated business.
	+ Value of your RRSP, IPPs, TFSAs, and non-registered investment accounts
	+ Do you have rental properties or other investments outside of your corporation?
	+ Passive income sources and their taxation rate.
	+ What is your current annual income as a physician? Is it steady, increasing or decreasing?
	+ What is your spousal income?
	+ Do you anticipate any lump sum payouts before retirement, like an inheritance?
Inventory of your Expenses or Potential Liabilities	− Document your expenses. • May include household, lifestyle or discretionary expenses. • May include annual costs associated with practice of medicine (CMPA, licensing fees, CME amongst others). • What significant one-time expenses do you foresee, like weddings, house down payments for children or dream vacations. • Do you anticipate supporting your parents or other family members. • Do you have alimony or ongoing child care responsibilities.
	− How much debt do you have personally and corporately? Your obligations may include mortgages, lines of credit, shareholder loans, and commercial debt.
	− What are your current monthly debt repayment amounts?
	− Do you expect to take on additional debt in the future?



How Much Do I Need to Retire?

Everyone's needs and wants are different. It is helpful to consider what your current 'burn rate' is (total of your annual expenses) and how that will change post retirement. Will you have or want to buy a cottage? Do you want to travel extensively? Are you travelling 5- star or camping? Will you be supporting your parents or will there be an inheritance? In the most basic way, post retirement annual spending in the range of 5% of your assets will balance the anticipated income from those assets, thus preserving your capital, colloquially known as your nest egg.

And for those of us who don't want or need to leave a "nest egg" at life's end, you may choose to go forward and spend away without consideration of preserving a nest egg. To those we say "may your last cheque bounce!"

How To Invest Before and After Retirement

There are many approaches to this. A common approach is to invest primarily in stocks rather than bonds based on the rationale that stocks perform better over the long-term than bonds. The key here is "long-term" as stocks are inherently riskier and more volatile with the better returns compensating for the heightened risk. Typically, if funds are needed over the next year or so, these funds should be available in bonds or cash so that they can be utilized without a risk of withdrawing from the market during a downturn. In general, one should prioritize tax advantaged accounts before investing in taxable accounts. Be wary of management and investment fees, these can quickly erode your investments. The majority of fees can be negotiated downward in the setting of substantive assets. The investment style you choose is the one you are most comfortable with.

Table 5: Investment Styles, Stock Market Investors

Style	Pros	Cons
Do It Yourself	Discount brokerage firms offers the cheapest commission	Little advice or handholding. Requires extensive time and research to build your expertise.
Full Service Broker	Provide advice but charge commission on both the buy and the sell side.	Fees are negotiable but can range up to 2%, which achieves significance over time. Inherent conflict of interest given there is financial compensation per transaction for the broker.
Fee Based Broker	A fixed fee is charged based on your assets.	Fees are negotiable but this can be expensive if you do not have sufficient assets.
Asset Manager	Discretion to trade on your behalf and will structure your portfolio to be in line with your risk profile. Trading costs are generally minimal but the fees are based on your assets.	Fees are negotiable, may range up to 1.7% but typically are about 1%.

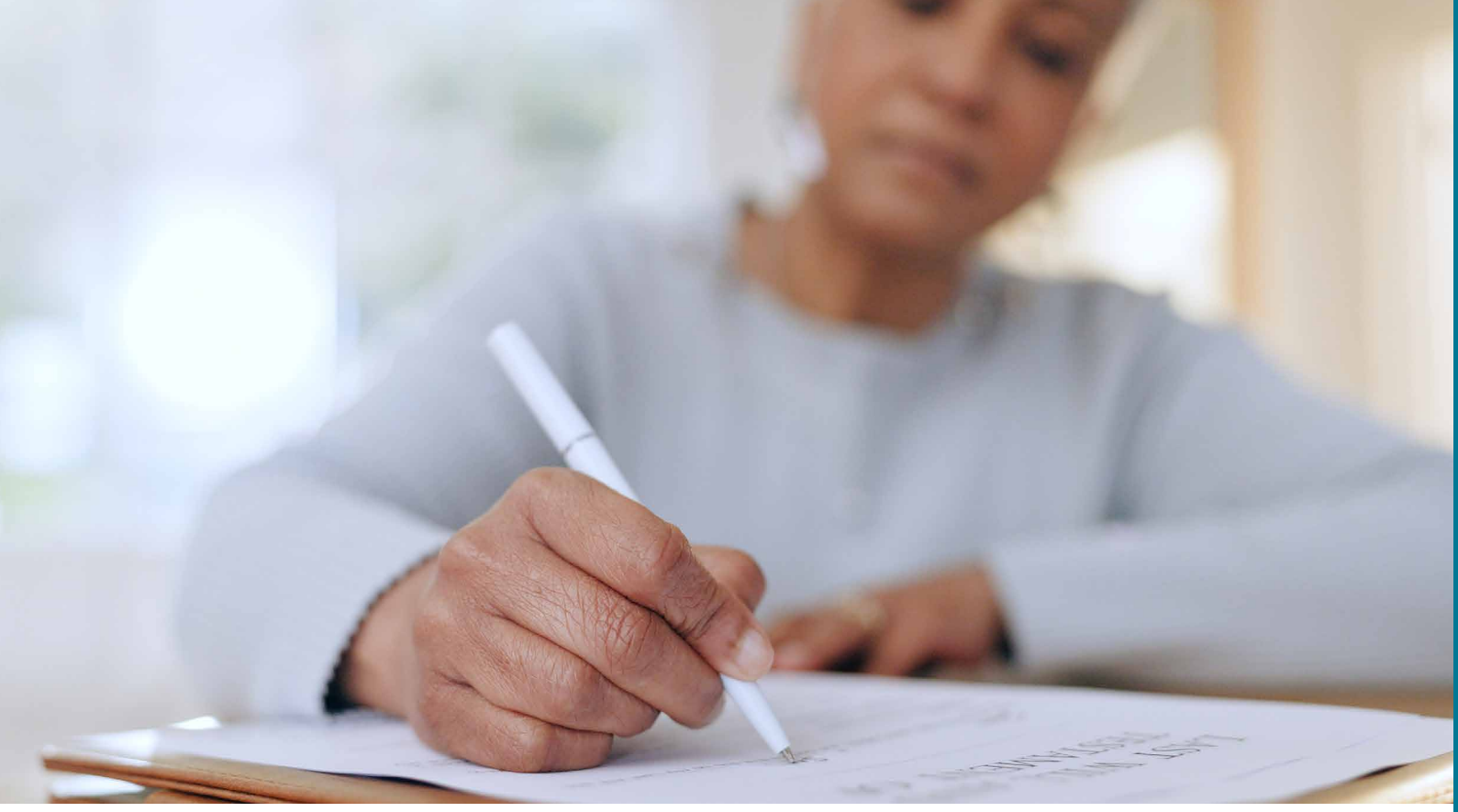
Who is The Right Person or Team?

Whoever you choose to go with, the most important thing is that you feel comfortable with the person you are dealing with. They should be asking you questions about your goals, risk levels and future plans. They should get to know you, understand when you are retiring and how much this will cost you. There should be a plan in place for how you will achieve these goals. We recommend seeking a referral based on a trusted source such as a lawyer, accountant, colleague or friend that can attest to that person.

Bring your sheet of assets and potential liabilities with you to a meeting. You may expect to receive a clearly written financial plan, 15–20 pages, which includes items such as tax, end of life implications and special consideration such as moving to another province or country. They should be comfortable letting you know what the honest risks are and when to be concerned. If they are only positive and wax on about how they have better returns than the next person, this can be a concerning sign.

Taxes — What Basics Do I Need to Know?

While taxes are inevitable, you should do everything possible to minimize taxes. This includes maxing Registered Retirement Savings Plans (RRSP) and Tax-Free Savings Accounts (TFSAs). The advantages of these funds are the tax-deductible contributions, tax-deferred growth while in the fund, and then on withdrawal they are generally taxed at a lower rate as income has decreased in retirement. The government prescribes how much needs to be withdrawn from Registered Income Funds. Canadian physicians can incorporate this as a vehicle for deferring personal taxes, income splitting, and providing



significant tax and estate planning advantages. While working, your MPC (Medicine Professional Corporation) may have paid you a salary or dividends, but post retirement can only pay out dividends. Your MPC will either need to be closed or converted to a holding company with a new name once you no longer hold a license to practice.

As of January 2025, physicians are eligible to join HOOP (Healthcare of Ontario Pension Plan) if they are incorporated and receive employment earnings from their MPC. Old Age Security is paid out to everyone who is eligible, typically in the range of $1,000 per month whereas CPP only pays out to those who have paid into it. There are multiple additional strategies to deal with taxes such as: Capital Dividend Account, Individual Pension Plans, Retirement Compensations Arrangement, Corporate Insured Retirement Plans, Retained Earning or Corporate Class Funds. This list is to acknowledge the complexity of potential tax scenarios and reinforce the need to seek expert advice.

The Will or Estate Planning

This is a critical component of financial planning. Elements may include choosing an executor for your estate and who holds your power of attorney for financial or health care decisions. These are legal documents which should be reviewed as life circumstances evolve.

Conclusion

Financial health and preplanning will pave the way for a fiscally easy retirement. Research suggests that more money leads to more choices, freedom, and feeling more in control of our lives and circumstances. So, although money cannot buy happiness, it can certainly enhance happiness when it is used as a booster rather than a primary goal. Happiness is a complex topic where money is just one of many factors. Nonetheless, good financial savvy and planning can be used to help us successfully navigate our transition to retirement.

08

Closing Reflections

This guidebook is only the beginning. It offers a framework, a starting place, and language to support conversations that are often difficult to initiate. Although this resource was originally developed for the Temerty Faculty of Medicine, we believe its insights are broadly applicable and can be helpful to physicians across medical practice in Canada who are navigating change at any point in their careers.

Yet no guide can fully anticipate the unique paths each of us will take or the unexpected turns that may arise. As E. M. Forster once said, “we are all in the dark about what the future holds.” What matters most is approaching these changes with kindness toward ourselves, flexibility, and the understanding that change is a natural part of our personal and professional evolution.

This Guidebook does not fully cover EDIIA considerations in late-career transitions and retirement. We endorse flexible, non-discriminatory pathways that accommodate age, gender, 2SLGBTQI+, Indigeneity, disability, and other identities. The Temerty Faculty of Medicine should actively address ageism and identity threats, ensure/support equitable access to reduced workloads, phased retirement, and mentorship, incorporate culturally safe planning, and remove accessibility barriers to support dignified, sustainable, and psychologically healthy transitions. We hope this guidebook will be the beginning of a broader conversation within TFoM to address, more specifically, EDIIA needs and opportunities during late-career transitions.

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