A guide for medical practitioners transitioning to an encore career or retirement

Controlling the exit from work and accumulating multiple resources early predict adjustment to retirement

The traditional approach to leaving a career in medicine has been informal. The fact that about 10% of medical practitioners in Australia are aged 65 years or over[1] — a seemingly natural consequence of increased life expectancy, improved quality of life and fluctuations in financial markets — highlights the need for a more methodical process for leaving medicine.

The final transition in a medical career is one that the profession has largely ignored, thereby risking unplanned departures that affect succession planning for practices, continuity of care for patients, and the wellbeing of the practitioner. The eventual introduction of proposed mandatory health checks for practitioners aged 70 years and over in Australia[2] may hasten the retirement of some, which only increases the urgency of retirement planning becoming a routine task for all practitioners.

The aim of this article is to describe a framework that examines how this transition may be achieved, so that practitioner wellbeing and adjustment to retirement are enhanced. For all the changes in medical culture that must occur — and to which the colleges, employers and other professional organisations must contribute — the individual practitioner ultimately remains responsible for their own welfare across the career cycle.

While this article is aimed mainly at clinicians, its principles remain pertinent to other medical practitioners.

Understanding the process of retirement

Retirement is not a lone event. It is better understood as a longitudinal process that comprises three phases that may overlap.[3] In the "pre-retirement" phase, the practitioner continues to work but may anticipate and prepare for retirement. In the "transition" phase, decisions are made about how and when the practitioner should approach stopping work. The final phase of "adaptation" may involve some paid work but the practitioner is principally retired. Each phase is considered a critical turning point, in which action or neglect can influence the outcome of subsequent phases. Some practitioners may chart a non-linear transition, moving in and out of work.

Any approach to determining the optimal time to transition out of a career in medicine must consider individual motivation as well as other competing factors. The first is the right of all and the desire of some older practitioners to continue working versus the extrinsic demands of family expectations or life events, such as illness in a loved one.

The second is the continued provision of clinical services by senior medical practitioners, usually within well established patient relationships, versus the right of patients to receive the highest level of care possible. In this regard, older practitioners are at increased risk of physical and cognitive changes that may potentially affect practice, such as poorer patient outcomes,[4] and may lead to being the subject of a complaint to a regulatory authority.[5]

Why retirement planning may be hard

When the transition away from work should start is an individual decision. Yet a cross-sectional survey found that more than one-third of older practitioners working in Australia had failed to even reach the pre-retirement phase, as they reported no intention of retiring or were unsure about doing so.[6] Moreover, not intending to retire was an occupational factor that predicted practitioners' perceptions of ageing successfully.[7] This suggests that even considering leaving work may be viewed as a sign of personal weakness.

Financial factors related to inadequate superannuation funds, continuing debt, or other commitments have been found to prevent retirement planning.[8]

Several other reasons for continued practice and delayed retirement, however, reflect more intrinsic difficulties in detaching from medicine. These include a feeling of responsibility for patients, a lack of interests outside of medicine, and a fear of potential changes in their relationship with a spouse.[8] These factors may be the result of a lifetime of work centrality whereby medicine takes precedence over other life roles.[6]

For many doctors, self-identity is bound up in their work and the drive to further their careers. A study of academics suggested that work–life balance was more nebulous because outside interests, including family, were considered an inconvenient distraction.[9] Conversely, emotional connections towards a workplace or institution may strengthen. Prioritising work limits social connections and creative pursuits, thereby perpetuating a reluctance to retire.

A structured transition to retirement plan

The purpose of adequate retirement planning is to enhance wellbeing after ceasing work. Pre-retirement planning is a long term goal-oriented behaviour that has been associated with retirement satisfaction.[10] In addition, retirement adjustment is predicted by the conditions of exit — namely, control over how and

Chanaka Wijeratne[1,2]

Joanne Earl[3]

1 University of Notre Dame Australia, Sydney, NSW.

2 Royal North Shore Hospital, Sydney, NSW.

3 Macquarie University, Sydney, NSW.

Chanaka.Wijeratne@health.nsw.gov.au

doi: 10.5694/mja2.50870

My plan for transitioning to retirement

I will accumulate the following resources:

- Physical resources
  - What am I doing to take care of my health (diet, exercise, adherence with medications)?
  - How often am I seeking independent health care, including consulting my general practitioner?
- Financial resources
  - How do I optimise my finances (reduce debt, maintain income)?
  - Who is my professional adviser? How often do I consult with them?
- Emotional resources
  - Who are the people I can connect with for emotional support? Who do I support in return?
  - Who do I know who has aged well and transitioned well? What can they share?
  - What types of professional assistance do I need to support the transition?
- Social resources
  - How do I maintain healthy relationships (spouse, children, family and friends)?
  - Who can provide professional support to help me manage these relationships now and when I am not working?
  - What relationships have lapsed that I want to re-initiate?
  - What interests can I develop or revisit?
- Cognitive resources
  - What intellectual pursuits outside medicine can I follow?
  - How do I want to learn, develop and grow?
  - What creative pursuits do I want to develop?
  - What courses or training might help to reposition me for an encore career?

My professional advance care plan

- I will discuss the timing of transition and retirement with my peers and loved ones
- I will engage my junior colleagues in a discussion about succession planning
- I will reduce my hours, stop procedural work etc, at age X or if the following health or practice problems occur ...
- I will stop working at age X or if the following health or practice problems occur ...
- I will set up a peer mentoring system with close colleagues so that we can provide each other with feedback on professional issues and review skill levels.

Encore career

- What are some professional aspirations I can pursue given greater time availability?
- How do I convert my passions and interests into pursuits?
- Do I want to focus on areas of expertise, governance, leadership or teaching and research?
- Was there a business opportunity I considered before my medical career that I want to revisit?
- What other career options have people who have successfully transitioned considered?

when one leaves work[11] — and resource acquisition in multiple domains.[12]

While the elements of planning should occur throughout the career cycle, we recognise that it is not a compelling consideration for many practitioners. We would still propose that all practitioners formally write an initial transition to retirement plan by the age of 55 at the latest, review it regularly, and the intervals between reviews should become more frequent with time (Box). The proposed introduction of the mandatory health check for practitioners aged 70 years or over should be an important incentive for self-care.

Traditional pre-retirement planning has tended to consist only of financial advice such as wealth creation, tax optimisation, and estate planning. This is an essential task as people tend to underestimate how much money will be required in retirement, but should not be used as the sole criterion of fitness for retirement. The more pertinent questions are how time in retirement will be spent and how much it will cost to support, rather than a pre-determined goal of wealth accumulation.

Resource accumulation

While adequate financial resources do contribute to retirement adjustment, so do adequate physical health, social engagement and emotional resources.[12] This means a much broader spectrum of planning that uses advice from multiple professionals is required.

Methods for optimising financial, physical and leisure resources are relatively easily sourced. What may be more difficult to manage, however, are the emotional resources needed to navigate the transition to retirement. In particular, the inevitable loss of self-identity may lead to anticipatory grief and bereavement.[13] That intending to retire is viewed as a mark of ageing less well by practitioners not only poses a considerable challenge for their retirement planning, but highlights the importance of understanding successful ageing in any discussion of transitioning away from full-time work in medicine.

Successful ageing is a concept that has evolved from a biomedical model, requiring an absence of physical disease and good physical functioning, to a more subjective notion that emphasises adaptation and autonomy.[14] A sense of engagement, a prominent feature of self-rated successful ageing, is inherent in the work of medical practitioners and is reflected in the pursuit of continued stimulation and learning, a sense of purpose and utility to society.[15] Successful occupational ageing is based on insight into personal strengths, a dynamic process of goal setting, generativity (guiding and mentoring the next generation), and self-care.[14]

There are a number of areas that are important for self-reflection, such as the original motivations for training in medicine, the reasons for continuing to work, the anticipatory grief of the loss of identity and role, and

the fear of ageing.[14] Not every practitioner will be capable of self-reflection, so that professional help may be required via a career development counsellor or vocational psychologist.

While many practitioners will set a pre-determined age or personal milestone at which to retire, others may continue to work indefinitely, thereby increasing the risk of practising with an impairment. This may be prevented by incorporating a professional advance care plan[16] that outlines a set of premorbid views about ongoing practice in the event that capacity to practise is impaired. Permission would be given to one or more people, such as a spouse, friend or colleague, to monitor fitness to practise and to provide regular feedback. "Red flags" to stop working may include physical illness or concern from a trusted source about deterioration in cognition or procedural or clinical skills.

Developing an encore career

Developing an encore career is the final aspect of the transition plan that allows the use of skills and experience developed over a career, and helps maintain meaning and engagement. Giving consideration to the encore career while still working enables the practitioner to better position themselves to access greater opportunities. Up until this point, the practitioner may have found integrating different life roles challenging and pursuing outside interests unnecessary.

An encore career can lead to feeling purposeful, provide goals to strive towards, and opportunities for intellectual and social pursuits. For example, a general practitioner keen to maintain patient contact but reduce caseload may want to specialise in an area of medicine (eg, mental health). Some may investigate governance roles with accrediting bodies, sit on guardianship or mental health review tribunals, or take up committee membership. Others may wish to provide leadership through directorships or management roles in hospitals or medical services. Others may wish to apply their lifetime of insights to teaching or research pursuits. Examples include teaching medical students, mentoring trainees, writing research grants and articles. It might be worthwhile revisiting those businesses or volunteering opportunities that were set aside before a medical career became the sole focus.

Conclusion

Retirement should not be viewed as a single endpoint but as an anticipatory process that involves the accumulation of social, emotional, financial and other resources. Active participation in retirement planning is essential to ease the transition, gain a better sense of control and enhance emotional adaptation. Encore careers provide the opportunity to capitalise on a lifetime of accumulated wisdom by integrating training, experience, interests and strengths. Given medicine's long-standing neglect of retirement planning, there is also a need for professional bodies to provide education about the transition process and for practitioners themselves to share stories of encore careers and inspire peers to explore avenues for transition.

Acknowledgements: We have received funding from the Avant Foundation to develop an online educational program for medical practitioners transitioning to retirement. The funding source has had no role in the planning or writing of this article.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed. ■

© 2020 AMPCo Pty Ltd

References are available online.

1 Australian Institute of Health and Welfare. Medical practitioners workforce 2015 [Cat. No. WEB 140]. https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015/contents/who-are-medical-practitioners (viewed Nov 2020).

2 Medical Board Australia. Professional Performance Framework. https://www.medicalboard.gov.au/Registration/Professional-Performance-Framework.aspx (viewed Nov 2020).

3 Earl JK, Muratore AM, Leung C, Yu TW. Career interventions: retirement. In: Hartung PJ, Savickas ML, Walsh WB; editors. APA handbook of career intervention. Volume 2, applications. American Psychological Association, 2015; pp 535–548.

4 Tsugawa Y, Newhouse JP, MacArthur JD, et al. Physician age and outcomes in elderly patients in hospital in the US: observational study. *BMJ* 2017; 357: 1797.

5 Thomas LA, Milligan E, Tibble H, et al. Health, performance and conduct concerns among older doctors: a retrospective cohort study of notifications received by medical regulators in Australia. *J Patient Saf Risk Manag* 2018; https://doi.org/10.1177/2516043518763181

6 Wijeratne C, Earl JK, Peisah C, et al. Professional and psychosocial factors affecting the intention of Australian medical practitioners. *Med J Aust* 2017; 206: 209–214. https://www.mja.com.au/journal/2017/206/5/professional-and-psychosocial-factors-affecting-intention-retire-australian

7 Wijeratne C, Peisah C, Earl JK, Luscombe G. Occupational determinants of successful ageing in older physicians. *Am J Geriat Psychiatry* 2018; 26: 200–208.

8 Pannor Silver M, Hamilton AD, Biswas A, Warrick NI. A systematic review of physician retirement planning. *Hum Resour Health* 2016; 14: 67.

9 Pannor Silver M, Williams SA. Reluctance to retire: a qualitative study on work identity, intergenerational conflict and retirement in academic medicine. *Gerontologist* 2018; 58: 320–330.

10 Topa G, Moriano JA, Depolo M, et al. Antecedents and consequences of retirement planning and decision making: A meta-analysis and model. *J Vocational Behav* 2009; 75: 38–55.

11 Wong J, Earl JK. Towards an integrated model of individual, psychosocial and organisational predictors of retirement adjustment. *J Vocational Behav* 2009; 75: 1–13.

12 Leung CSY, Earl JK. Retirement resources inventory: construction, factor structure and psychometric properties. *J Vocational Behav* 2012; 2: 171–182.

13 Climent-Rodríguez JA, Navarro-Abal Y, López-López MJ, et al. Grieving for job loss and its relation to the employability of older jobseekers. *Front Psychol* 2019; 10: 366.

14 Peisah C. Successful ageing for psychiatrists. *Austral Psychiatry* 2016; 24: 126–130.

15 Jeste D. Successful aging of physicians. *Am J Geriatr Psychiatry* 2018; 26: 209–211.

16 Saver JL. Best practices in assessing aging physicians for professional competency. *JAMA* 2020; 323: 127–129. ■