Retirement plans and perspectives among general surgeons: a qualitative assessment

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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 yr, had slowed down practice or planned to slow down within 5 yr, 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.

Contexte : Les plans de retraite des chirurgiens généraux ont de vastes répercussions, tant à l'échelle personnelle et professionnelle qu'à l'échelle des systèmes de santé. Nous avons analysé les facteurs qui favorisent ou retardent le départ à la retraite des chirurgiens afin de dégager les éléments qui pourraient favoriser une planification de la retraite échelonnée tout au long de la carrière.

Méthodes : Nous avons procédé à une étude qualitative entre mai et octobre 2016 à l'aide d'entrevues téléphoniques structurées (durée moyenne 29 minutes) auprès de chirurgiens généraux de l'Ontario. Nous avons utilisé une stratégie d'échantillonnage par choix raisonné pour recruter des chirurgiens à 3 stades de carrière (ne prévoyant pas prendre leur retraite d'ici 5 ans, ayant ralenti leur pratique ou prévoyant la ralentir d'ici 5 ans, et ayant cessé d'occuper un poste de chirurgien principal). Nous avons analysé les données à l'aide de techniques d'analyses thématiques reconnues.

Résultats : Nous avons interrogé 22 chirurgiens généraux dont la situation par rapport à la retraite allait de la retraite complète à l'absence de plan de retraite. Les thèmes principaux étaient le maintien de la réputation et de la qualité de soins, l'engagement et planification successorale et la planification de la retraite. Les plans des chirurgiens en milieu de carrière et « seniors » se faisaient plus tard durant leur parcours professionnel et étaient motivés par le souhait de préserver leur réputation et leur identité en tant que chirurgiens. Le départ hâtif à la retraite des chirurgiens plus jeunes (≤ 50 ans) était motivé par des choix de style de vie et par l'environnement de travail. Des obstacles logistiques et l'insécurité financière ont pu retarder certains départs à la retraite.

Conclusion : Les chirurgiens commencent à planifier leur retraite tôt et tard en cours de carrière. La plupart des chirurgiens souhaitent planifier leur retraite de manière à pouvoir réduire graduellement leur charge de travail auprès des patients et créer des possibilités d'emploi pour leurs jeunes collègues, tout en maintenant un apport équilibré et continu à la profession. Les mesures visant à soutenir les chirurgiens dans la planification de leur retraite à tous les stades de leur carrière devront faire l'objet d'études plus approfondies.

Retirement from surgery is both a deeply personal and a public matter. Surgeons' decisions about retirement and late-career transition are important for their sense of personal and professional identity, and for workforce planning and patient safety.[1,2] Today, practising surgeons are older, and many are delaying retirement, while specialty-trained new graduates compete for a dearth of permanent jobs.[3–5] The potential impact of age-related physical and cognitive decline on surgeons' clinical performance has been noted.[1,3,4,6] However, the relation between aging and performance is but one consideration among many in the complex decision-making process that retirement from surgery and medicine involves. For many reasons, retirement may be embraced, approached with trepidation or actively resisted.[7]

Hospitals and academic departments are calling attention to the need for better support and involvement in physician retirement planning.[8] We are only beginning to understand the intricacies and experiences of decision-making regarding physician retirement and late-career transition. A recent review showed that most physicians retire between ages 60 and 69 years, with many delaying retirement because of financial insecurity, lack of other interests or fear of change in their personal lives and identity.[9] Few investigators have looked specifically at the perspectives and retirement experiences of surgeons, which may be different from those of other physicians, such as internists, as surgeons are dependent on hospital resources to practise.

Previous research examining surgeon retirement decisions has been largely quantitative, and limited research has been published since 1994.[10] Although such survey studies identify what surgeons' attitudes toward retirement are and describe their prevalence, qualitative research provides complementary in-depth data about attitudes and beliefs. In the current study, the qualitative approach aims to understand how and why surgeons' beliefs around retirement are formed; it explores the meaning of surgeons' perspectives and contextualizes them within a surgeon's lived experience. Such data can provide useful insight into surgeons' retirement wishes, needs and plans, and can guide program development and supports. Therefore, to capture surgeons' experiences of drivers of and barriers to retirement, we sought to consolidate Ontario general surgeons' perspectives and experiences around retirement and late-career transitions. Our goal was to identify opportunities to support surgeons' retirement planning in ways that preserve surgeon satisfaction and quality of life, optimize patient safety and inform surgical workforce planning.

Methods

Design

We conducted a qualitative study using inductive thematic analysis from May to October 2016.

Recruitment and sampling

We invited general surgeons registered with the College of Physicians and Surgeons of Ontario to complete a self-administered paper survey about retirement decisions.[11] On survey completion, respondents were asked to express their interest in participating in a telephone interview (conducted by L.G.C.) on the same topic. Sixty-two surgeons expressed interest and provided their contact information. We then used a purposive sampling strategy[12] to recruit participants at 3 career stages as identified in the survey: 1) no plans to retire within the next 5 years, 2) had slowed down surgical practice or planned to slow down within 5 years and 3) no longer operating as the primary surgeon. We also sought to achieve balance with respect to participants' sex, practice location in a community and academic status (academic-affiliated [i.e., some teaching] or academic setting).

Data collection and analysis

We developed a semistructured interview guide that was informed by the results of the previously administered survey and the literature on physician retirement.[7–9,13–15] The interviews explored participants' early and most recent practice and professional contributions, and their perspectives, preparations, plans and experiences around retirement. Seven pilot interviews were conducted (L.G.C.), audio-recorded, transcribed verbatim and discussed (L.G.C., F.C.W). The interview guide was adjusted with minor wording modifications, and the remaining participants were interviewed. All interviews were included in the final analysis. The interviews lasted on average 29 minutes.

We collected and analyzed the data iteratively and inductively, using established techniques to identify major themes and subthemes.[16] The data were coded independently by both authors following principles of thematic analysis and were interpreted collaboratively through ongoing discussion and literature review. Data collection ceased when we determined there to be sufficient depth, breadth and redundancy in the major themes that were derived from the interviews to offer a complete and sensible explanatory narrative.[17] This narrative reflects confirming and disconfirming data that characterize the range of responses within the larger themes identified.

Results

We interviewed 22 general surgeons. Seven participants were no longer operating as the primary surgeon or were fully retired, 7 participants had slowed down or planned to slow down their practice within 5 years, and 8 participants had no current plans to slow down or retire. The number of years in practice ranged from 5 to 48. Twelve participants had held the position of chief of surgery, 7 had been

a division head of general surgery, and 1 had been chief of staff. Participant characteristics are further detailed in Table 1.

Preservation of reputation and quality care

Preservation of reputation and quality care were dominant and related themes discussed that encompassed notions of competence, reputation and professional identity. Preserving one's reputation and providing safe, quality care were main drivers described for slowing down and retirement planning among participants aged 50 years or more. Many participants planned to stop working as the primary surgeon before any noticeable deterioration of surgical or cognitive skill occurred; however, they also recognized the challenge associated with self-assessment. Several drew on experiences of watching respected colleagues and excellent surgeons poorly navigate this terrain to explain planning their own timely retirements.

> The biggest trigger for me was seeing how unpleasant a few of the surgeons here retired, how the process was more one of being asked to leave rather than leaving. We've had 2 or 3 surgeons who were excellent surgeons, but they did deteriorate over the years, and they stayed well past the point of where they should have, and I just didn't want to see myself in that situation. I wanted to plan a little bit, and I wouldn't say retire gracefully but retire while I still wasn't causing damage or harm to people. (P02)

In the interest of reputation and patient safety, many participants reported that they were relying on colleagues to tell them whether they appeared to be losing competence. In the academic centre, peer review was perceived to be more accessible and structured through morbidity and mortality rounds. Among community surgeons, there was an overwhelming reliance on informal peer assessment to appraise competency; however, participants commented that it was not an ideal barometer for retirement readiness, as many perceived that, by the time colleagues commented on competency, it was likely already lost.

> You'll never have people come and tell you that they think it's time you retire until after you've done a series of bad moves, and even for the first few nobody's going to say anything, they're going to hope that you do something. (P11)

Professional identity presented as a driver of delayed retirement. Participants, especially those who had reduced their practices, described how being a surgeon defined them, and the desire to preserve this shaped retirement planning and experiences. Loss of social status and loss of sense of purpose were described by some participants, along with the need for lifestyle planning to maintain interests outside of surgery in order to mitigate these feelings.

> It's really important to make sure, throughout your life, that you have other interests, whether it's hobbies or passions, or things you'd like to do to make sure that you continue to foster those things and keep them going so that, when you do retire, you're not feeling lost and without a purpose. Because I've certainly seen many surgeons [who] have retired and they're happy for a month and then they get totally bored and they've defined themselves as a surgeon, that's the only way they define themselves. And if they're not doing surgery anymore, then they lose their sense of purpose. (P03)

One retired surgeon described an initial retirement experience in light of this sense of loss:

> I really didn't want to retire, but the chief of staff thought that I was 75, and he thought that I should quit. And I agreed and then I regretted it. When I retired and closed my office and got my room in my upstairs bedroom all set out, I looked out the window and I thought "What will I do now?" (P21)

For some participants, retirement plans to work part-time as a surgical assistant were viewed as a means to uphold their surgical identity and a sense of fulfillment while helping their colleagues, learning and continuing to contribute.

Commitment and succession planning

A prevalent theme of commitment informed participants' perspectives on succession planning to support the next generation of surgeons and assure that patient and community needs were met. Participants in academic centres and larger communities described the effects of the current job shortage on new graduates, who were competing

Table 1. Participant characteristics

Characteristic	No. (%) of participants *n* = 22
Practice type	
Academic	8 (36)
Academic-affiliated	7 (32)
Community	7 (32)
Sex	
Male	17 (77)
Female	5 (23)
Age, yr	
36–40	1 (4)
41–45	2 (9)
46–50	3 (14)
51–55	1 (4)
56–60	6 (27)
61–65	3 (14)
66–70	2 (9)
71–75	2 (9)
≥ 76	2 (9)
Retirement status	
No plans to retire	8 (36)
Had slowed down or were planning to slow down within 5 yr	7 (32)
No longer operating as primary surgeon	7 (32)

against many other qualified surgeons for 1 job or choosing from available positions for which they had not specifically trained. Many participants felt that senior surgeons should relinquish their positions and step aside to create opportunities for younger surgeons, which would directly benefit not only the individual but, in academic centres in particular, the growth of the surgical program as a whole.

> I think as a surgeon you have to anticipate that at some point you do have to stop doing this. You have to set an example for the younger people and open up that opportunity for somebody to come along. And invariably they will bring new things and new skills. (P10)

Succession planning was enabled to some extent by introducing yearly discussions initiated by department heads. Academic surgeons described an increasing tendency for division chiefs to ask about late-career plans with a view toward recruitment planning. These discussions were generally well received in that context. Participants who had informally discussed impending retirement plans with colleagues experienced collegial support or, for some, collegial requests to delay.

For surgeons in rural communities, commitment to succession planning was described with respect to assuring that community needs were met. In these settings, little to no informal or formal discussion of retirement was had among surgical groups, which made planning difficult, if not impossible. In smaller communities, this possibility was felt as a real threat to patient safety:

> Most of the time we cross our fingers and hope nobody's retiring, because we're literally 1 surgeon away from catastrophe. (P19)

In these settings, unexpected questions about retirement plans from hospital administrators were sometimes experienced negatively as professional criticism or as a lack of respect or gratitude for service to the community. Proper succession planning was viewed as a necessary but underused means to protect community needs:

> I think that some surgeons in small communities put themselves in a position where they feel that they're indispensable because they're capable of doing such a wide variety of procedures that they think "How I will ever be replaced?," and that's true to an extent. But it's a shame to get to the point where suddenly something happens to you and you just have to step out, and then the community really is in the lurch because they haven't been able to prepare. And that's an issue, I think, that surgeons in smaller communities need to be aware of. (P22)

Retirement planning

Early retirement planning was more likely among the 5 youngest participants than among their older colleagues. The former planned to reduce or completely stop practising surgery in their 50s; 2 community surgeons had carefully planned financially for the option of leaving surgery exactly at age 50. The sixth-youngest participant, also a community surgeon, planned a late retirement, expecting to reduce his practice after age 70. Forethought and planning extended beyond financial preparation to acquiring skills to prepare oneself for second full-time career, either within medicine (e.g., as a hospital or university administrator) or completely outside of medicine. The decision to leave surgery early for another focus was explained by a desire to work but not only as a surgeon. Participants cited lifestyle choices and toxic departmental politics as drivers of early retirement from surgery.

> I watch my partners at 65 years old, and I've got 1 partner who's 68 doing call and [doesn't] complain about it, but I don't want that. (P05)

By comparison, many participants aged 61 or more were less meticulous and definitive about their financial and retirement planning. Among academic and academic-affiliated surgeons, 70 years was the projected age for fully stopping work. Some participants reported not thinking intentionally about career transitions or reducing surgery until around age 60. However, some degree of financial planning was described by all participants. Not surprisingly, financial security was the most discussed enabler for reducing practice or retiring altogether, with many participants cautioning about the importance of financial responsibility. Those who had experienced financial setbacks through divorce or illness felt the need to work longer to catch up financially to maintain their lifestyle, however modest it may be. Those planning to reduce their surgical practice within 5 years described plans to restrict cases, gradually hand patients over and reduce their call schedules while maintaining some form of income. Participants' experiences arranging part-time surgery ranged from being well supported by colleagues to experiencing difficult negotiations. In addition to retreating from the on-call schedule, participants encountered individual-level barriers. Care continuity was found to be challenging as a part-time clinician, as was finding a satisfying alternative to operating.

> I've been thinking about taking on other administrative roles. I've looked into health agency positions, and I've looked into administrative roles just to see if that would be something of interest — they haven't been that interesting either. (P15)

The greatest perceived barrier to slowing down one's practice was the connection between access to hospital resources and the on-call schedule. This is a situation unique to a publicly funded health care system such as in Canada. Many participants described the increasing effects of postcall fatigue in their 60s as a key consideration in their plans to slow down; however, the desire to cut back in some environments meant complete and necessary cessation of all surgical activity, which weighed heavily on retirement decisions, as elective operating room time was tied to on-call service.

> The rule of thumb here is that, if you retire, you give up all other facilities. And we have to be on full-time call if we're getting any of the [operating room] or minor surgery facilities to use. So it's an all-or-none phenomenon. You either do call and work hard, or retire. So, it's been a difficult thing to kind of phase down. I've been thinking about slowing down for several years, but it seems almost impossible. (P07)

This influenced the retirement plans of a number of participants working internationally who had already reduced or planned to reduce operating as primary surgeon in Canada to work abroad. Unless well supported by colleagues, winding down but working enough to keep up one's skills for international opportunities was challenging.

To accommodate desires to reduce surgery, several participants described novel practice models that would help achieve their professional and lifestyle goals. One such model was a shared practice, whereby 2 surgeons equally shared 1 full-time-equivalent job. This proposed model did not receive support from departmental colleagues, who perceived it as "stealing work" (P06): the perception was that 2 surgeons, despite sharing practice, were doing more than 1 surgeon's clinical work volume. A mentorship arrangement partnering new and senior surgeons was also endorsed as a mutually beneficial model.

> I would love to be able to bring on a younger surgeon in their late 30s, when I'm near 60. And they could learn a lot from me. I could learn a lot from them, and I think they'd benefit from getting a job, and getting into the system. And I could benefit by trying to get out. (P14)

Discussion

In many ways, general surgeons in this study were found to share the perspectives and experiences of other physicians when considering or planning for retirement. Academic and nonacademic surgeons alike articulated a clear commitment to their profession and patients as well as a strong occupational identity, which is common in medicine and is believed to influence retirement decision-making.[14] Like other physicians, the participants in the current study maintained the importance of preserving their reputations and providing quality care. However, surgeons differ from other physicians in that surgical work requires not only hospital structure and resources but also a technical capability that must be adequately reinforced and maintained. In other words, surgeons do things to people in ways that other physicians do not, which requires access to hospital resources as well as constant practice. As a result, many surgeons are challenged to implement plans to reduce their practices and scale back their call schedules but still have sufficient access to elective operating room time to maintain their skills and generate income. Several participants in the present study experienced this situation, describing the all-or-none phenomenon, which may contribute to delayed initiation of retirement, and what retirement would mean for themselves, their surgical partners and their own practices, given its fullness and irrevocability.

Previously, surgeons' tendency to delay retirement planning was attributed to a lack of insight about age-related decline and/or perceptions of superiority.[6,18] Our findings suggest that neither lack of insight nor arrogance appears to play a role in delaying retirement for the average surgeon. More important, developing and negotiating a satisfactory slow-down plan in an environment with seemingly impossible logistical barriers contributes greatly to perceived deferral and delays. Academic surgical programs have begun to implement plans to support individual surgeons' retirement needs, taking such factors into consideration.[8] Such plans can support and guide surgeons in the retirement-planning process by identifying possible pathways that take into consideration surgeon interest and capabilities, surgeon financial and retirement goals, hospital resources and patient need. For instance, academic surgeons may be well positioned to continue to contribute to trainee education or quality-improvement efforts while decreasing operating. While no 2 retirement pathways will be identical, resources geared toward enhancing the surgeon experience will best position all surgeons to imagine and prepare for feasible, enjoyable and rewarding late-career work options.

In addition to retirement's being logistically complicated, many senior surgeons in the current study expressed a sense of loss associated with retirement, consistent with other physicians' experiences.[9] Although most retirees and semiretired participants reported being happy, this career and life phase was not viewed entirely as an achievement. Rather, it was described as a necessary and inevitable process.[13,15] Retirement among surgeons has historically been associated with some measure of ambivalence and reluctance.[6,14] It has been suggested that surgeons' lack of self-esteem, fear of death and resistance to change contribute to this.[6,19] Moreover, surgeons have reported that they do not make retirement plans that they consider to be a satisfying alternative to operating.[20] This highlights the intrinsic meaning of surgical work, which may also contribute to a sense of loss. This was certainly described by a few older participants in the current study, whose efforts to test the waters of part-time work outside of surgery had not immediately led to a fulfilling alternative. By comparison, younger participants viewed retirement as something to look forward to, something that would be earned by working hard and saving or investing wisely. Financial planning to ensure that earlier retirement could be achieved was even described in some detail in these instances, in contrast to what has been reported among academic physicians more broadly.[21] This may reflect a generational shift in the formation and prioritization of work identity among younger surgeons, for whom, in our study, work–life balance was extremely important and being a surgeon was not all-consuming.

To ultimately avoid losing a sense of oneself in late-career transitions, physicians are encouraged to discover ways early on to "diversify" themselves, fostering interests outside of medicine that can become of greater focus and pleasure during retirement.[15] Several participants in the current study emphasized the importance of such lifestyle planning, which they expected would ease their transition into retirement, with interests in sports, music, travel, family and socializing to pursue. Within academic surgery programs, opportunities exist to establish transition positions, such as a professor emeritus role with a focus on teaching and mentorship. In their increasingly occurring retirement discussions with faculty, surgery chiefs may become responsible for gauging interest among senior faculty for assuming such a role and for developing a job description and agreement. Flexible but stable opportunities for retiring surgeons in academic surgical programs are likely to improve surgeons' outlook and experiences with retirement planning.[9] Likewise, among community surgeons, part- or full-time work as a surgical assistant may be increasingly available given the loss of family physicians in hospitals. Most retirees in our study reported positive experiences assisting junior colleagues, deriving personal benefits including learning, a sense of contributing and a small income. Participants also expressed interest in job-sharing models, which could be more widely explored given the rise in surgeon unemployment in some areas[5] and the potential benefits of a mentorship model.[22]

Finally, participants in the current study considered self- and peer-assessment and their relation to perceptions of retirement readiness to be important factors in retirement decision-making. Several participants hoped that colleagues would let them know when they should stop practising, with some making verbal agreements to do so. It has been shown that physicians do poorly when it comes to accurate self-assessment on performance,[23] which may limit their ability to recognize when retirement may be appropriate. Yet peer assessment may be equally unsuitable as a metric to inform retirement, as "knowledge, experience and reputation can compensate for a long time"[6] in the face of declining technical skill and cognitive resources.[18] Alternative methods of assessment for older surgeons must therefore be explored and implemented to appropriately inform retirement decisions without reliance on subjective, likely uncomfortable colleague impressions.[18] For instance, the Aging Surgeon Program at LifeBridge Health, Baltimore provides guidance and protection of surgeons through unbiased comprehensive assessment of cognitive and technical skill to advise on retirement decision-making, among other things.[18] Such a program offers an objective tool to help aging surgeons plan and prepare for retirement while upholding and reinforcing the values of quality care and commitment to their work that defined their surgical career.

Limitations

Qualitative research is inherently interpretive and characterized by subjectivity and reflexivity. Despite the recognition that "all data are theory-, method- and measurement dependent,"[12] concerns about sources of bias in our study may be present. However, we used established techniques to ensure that our methods were rigorous by qualitative research standards and that our findings are robust. We developed our interview guide to explore salient topics and concerns identified by surgeons in our previously published survey study.[11] Our purposive sampling strategy yielded a varied sample of surgeons from different clinical settings with a wide range of experience and opinion on retirement. Interviews were conducted exclusively by L.G.C., a seasoned social scientist who was able to maintain a critical distance from the data while capturing participants' situated perspectives (i.e., emic perspective).[12] Both authors read and coded all interview data, engaging in iterative discussion of findings throughout data collection. This type of investigator triangulation and collaboration allowed for 2 different analytic lenses to code and interpret the data. Consistent with qualitative sampling, we continued to collect and analyze data until thematic saturation was achieved across the sample of participants.

Conclusion

In this qualitative study, we found that most general surgeons wished 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. They were also committed to preserving quality care and their surgical identity. A key finding is that logistical barriers often prevent surgeons from slowing down their practice in their preferred manner. Opportunities exist to support general surgeons at all career stages in their retirement planning, and these should be further explored. Recommendations that emerge from this study include leveraging department resources, establishing transition positions for retirees, exploring innovative job-sharing and mentorship models, and highlighting the intrinsic benefits of part-time surgical opportunities.

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