# Towards Retirement: Managing those last years of practice


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**Introduction**

Ageing can be defined as a complex, variable, multifactorial process associated with numerous gradual declines in physiological function (that will inevitably lead to death), Chronological aging starts at birth and ends with death. In New Zealand almost 20% of anaesthetists are older than 60 (in comparison 15% of the USA workforce >65).

**Physiological Changes**

Physical functional capacity begins to decline from age 30 with a reduction of lean muscle mass and reduced reflex time however regular exercise can keep this almost unchanged between the ages of 45-65. Vision becomes impaired with conditions such as cataracts, glaucoma, age-related macular degeneration and accommodation, contrast sensitivity and visual acuity all decline. Hearing becomes progressively less sensitive, with losses being most significant at higher frequencies – important for alarm recognition and all chronic conditions or illness (e.g. musculoskeletal problems and ischaemic heart disease) increase with age. 89% of older anaesthetists who continue working however usually assess their health as Good to Excellent perhaps through self-selection. Cognitive decline, as measured by the MicroCog™ assessment tool, is often precipitous. Decline occurs with increasing age in the areas of cognitive function, inductive reasoning, verbal memory, and overall reasoning. Physicians generally score highest in cognitive functioning from ages 25-55 with little change between 55-69 and 70+. After age 60 domains such as processing speed (dealing with incoming information quickly and efficiently), working memory (short-term memory maintenance of new information) and episodic memory encoding (formation of new memories of specific events or episodes) decline. In one recent study however, the majority of practicing senior surgeons performed at or near the level of their younger peers on all cognitive tasks, as did almost half of the retired senior surgeons, one third of practicing surgeons in their 70s still matched younger surgeons in competence on a variety of learned tasks. Domains such as semantic memory (knowledge) and more "routine" behaviours" show little change; one possibility is that older adults use preserved knowledge and experience to form more efficient or effective strategies when performing tasks in which younger adults rely on processing ability i.e.: less experienced practitioners may rely on slower conscious deliberation or type two thinking. As physicians age therefore they are more likely to make errors from placing undue weight on first impressions but their ability to reach a diagnosis when minimal information is available improves with experience. Subjective cognitive loss equates with 4.5 x risk of progression to Mild Cognitive Impairment (MCI) within 7 years.

Dementia has a general incidence of up to 13% depending on the definition and a "cross over" with mild cognitive impairment of 10-20%. This appears to be the group that makes up a large proportion of the doctors referred to medical bodies and is responsible for up to 63% of all the causes of medical adverse events. Most, sadly, are determined to be preventable. Sleep quality reduces with age and sleep time becomes shorter. Tiredness can affect older doctors' performance and mood and cognitive performance of older shift workers may be more impaired during night work but they may be less aware of their degree of impairment than younger shift workers.
Simple "on-call" can be highly disruptive of sleep even when not called out but physicians with young children can also suffer chronic sleep deprivation with resultant impairment too.

**Assessment**

Unfortunately recognition of incompetence is very difficult and complex and the literature rather empty on this topic. There is extensive material on confirmatory testing once identified but there is a deafening silence regarding solutions. Most physicians have a limited capacity to self-assess their competence or ability and this is biased by multiple factors such as financial need, self-esteem etc. External assessment is essential but difficult especially for those in isolated private practice. Impairment risk increases from public practice through group private practice to solo private practice and retirement from public to private at career end "only a few years left to maximise my

income". Most older anaesthetists in good health continue to perform well but they have a responsibility to demonstrate insight into the potential impacts of ageing and be open to collegial advice regarding competence, to take the initiative, make plans for the future and discuss these issues within their department/private practice. There is very limited evidence that on-going education, 360 degree peer reviews, practice reviews, chart reviews are helpful. There is evidence for simulation, medical assessments and neuro-cognitive assessments but these are also very stressful for the practitioner. The older Anaesthetist needs to be cognisant of the 'human factors' involved, it is easier to support those who demonstrate humility listen to and take advice from colleagues, seek guidance at work if required and assess the work they do regularly.

**Towards Retirement**

General "job planning" changes might include daytime weekend work instead of overnight on-call, flexible working conditions with shorter working hours, less isolated working and less demanding or less stressful lists. Role changes might be appropriate for some such as pre-operative assessment clinic work, undergraduate or postgraduate education, clinical governance or other non-clinical roles. It's never too early to start planning, busy medical careers don't help but that should not be allowed to prevent planning, about 67% of anaesthetists "slow down" over a period of time to allow for transition. All new consultants should have a session with an appropriate "planner" for advice on practice insurance, life insurance, accounting, superannuation planning, GP, work life balance as the part 3 course recommends and possibly covered by their CPD allowances. Repeated every 10 years or so this can focus career options too. At around age 55 another session with a "life coach" and serious "life planning" is recommended. Ongoing sessions including a financial planning update, family situation, social structure, retirement occupation and hobbies is useful.

**Retirement**

Successful aging is multidimensional and encompasses physical health or freedom from disease, functional health or independence, psychological health or mental health and social health or active engagement although luck and genetics play their part. The decision to retire is influenced by personal health, financial status and pension arrangements, perceived status, family commitments job satisfaction and employer attitudes and norms plus working hours and the availability of work. With present day longevity this is a new "career" "The Third age" and may be up to 30% of one's life. In the US only 55% of older anaesthetists rate their financial status as good or excellent often as a result of poor planning.

**Financial Planning**

There are numerous on-line sites for this sort of information but some suggested goals include aiming to have ones annual salary saved by age 35, three times ones salary saved by age 45, five times saved by age 55 and eight times by age 65. Obviously mortgages, commencement of employment and student loans may prevent this exact progression. According to the "four percent rule" savings of $4 million are required by retirement to live on an annual pre-tax income of $160,000 every year throughout retirement or 25 x the desired gross annual "income". There are also many other ways of calculating what you can or should spend. Maximise drawdown to 75 or 80 then live on the government pension only, "Leave no inheritance" High spend at the start (ie "run out" - at "expected" calculated or programmed exit date), "Leave an inheritance" – fixed annual spend which remains unchanged throughout retirement (ie expect to "reduce expectations") or a "mix" – the general norm.

The seven big expenses from 55-65 versus 65-75+ are: Housing (34% of spending) – generally falls (20%), Transport (17-18%) – generally falls (10%), Food (12 - 24%) – slight fall (inflation) (7%), Pension Saving (13 -6%) – drops significantly (60%), Health Care (insurance & costs) (8 – 13%) – rises (20%), Entertainment (5 – 6%) rises slightly (10%) and Other (personal habits, care products, travel) (10-11%) - rises (15%). Overall expenses tend to reduce by up to 85%!

**Happiness in Retirement**

Have a purpose that gives you a reason to get up in the mornings and stay engaged. Downshift your lifestyle to be a more relaxed person with a simpler low stress life. Build up an 'inner circle' of friends who also have healthy habits and challenge you mentally and regularly meet and share good food. Be likable, 'Of the centenarians interviewed, there wasn't a grump in the bunch.' Put family first - signal that this is so with family rituals and importantly try new things.

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