

Lost in transition? Thoughts on Retirement Part 2. “Should I stay or should I go now?”

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ABSTRACT

While accepting that oncologists should plan for a future beyond full-time oncology, there is little practical guidance for a successful transition into retirement. Previously, we provided strategies for various aspects of retirement planning. However, this became significantly more complicated as we face newer issues such as; the COVID-19 pandemic,

the move to virtual patient care, greater awareness of burn-out, as well as the increasing burden of regulatory issues such as the electronic medical record (EMR). It is evident that more prospective information is needed to guide oncologists in planning their retirement. *The Oncologist* 2021;9999:••

INTRODUCTION

Just over 7 years ago we acknowledged Sir Paul McCartney, who despite writing “Will You Still Need Me, Will You Still Feed Me, When I’m sixty-four” when he was 16, was still having to work well into late seventies[1]. Possibly the result of poor financial planning? At that time, we tried to offer oncologists guidance on planning for their transition into retirement. Since our initial article, there have been many advances both technologically and in the field of medical oncology, as well as a devastating COVID-19 pandemic, which has changed the way in which we live and work. This time we pay homage to The Clash and their song, “Should I Stay or Should I Go”, again perhaps written with the subliminal message of retirement planning? Many of us who are near, at, or past retirement age are now begging the question; “should I stay or should I go now?” This article looks at how events both inside and out of oncology have impacted the decision to retire. In Table 1 we have summarized our previous publication and added some details on how we think these topics have evolved. In the text we expand on how some common themes have evolved, but place greater emphasis on subjects that we could not have anticipated back then such as; COVID-19, the move to virtual patient care, the relentless progression of the EMR and regulatory challenges, as well as quite simply, is oncology

advancing so fast that it is difficult for some of us, “old timers” to keep up?

WHEN DO ONCOLOGISTS TEND TO RETIRE?

While retirement remains a very personal decision, many of us will ask when do most of our colleagues retire? In our original article, we talked about the “sea of grey” to describe the audience at most cancer conferences as possibly a reflection on the advancing average age of practicing oncologists[1]. We cited an ASCO survey of US oncologists which anticipated that 54% of practicing medical oncologists would be 65 or older by 2020. This survey also showed the expected retirement age for respondents was 64.3 years[2]. We know now that one in five US oncologists are aged 64 years or older[3].

HOW THE WORLD HAS CHANGED SINCE 2013!

The COVID-19 pandemic

It has now been a year since COVID-19 upended lives around the globe. This pandemic led to an abrupt, urgent and unforeseen change in how we live our lives and

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practice medicine. The European Society for Medical Oncology (ESMO) Resilience Task Force study found that 78% of respondents had increased concern for their personal safety since the onset of the pandemic[5]. This is ever more important with an aging of the workforce, that puts them at higher risk for complications from COVID-19 infection.

As work has possibly become less appealing, the current restrictions put in place due to COVID-19 have paradoxically also made retirement much less attractive. Retirees who spend lifetimes dreaming of travel, spending time with their grandkids or simply enjoying their newfound freedom, now have to accept their confinement. They might be leaving “normal” social interaction with colleagues at work to spend the majority of their days alone or with their spouses.

THE SHIFT TO TELEMEDICINE “VIRTUAL CARE”.

In the wake of COVID-19, clinicians took to telehealth to continue providing services to their patients via telemedicine. There is no doubt that telemedicine has many undisputed and proven benefits to the patient when it comes to improving convenience and access, while reducing COVID exposure risks and travel expenses for the patient. However, there could be some unintended negative consequences for the clinician[6]. Studies have documented the increased clinician burnout due to screen fatigue, potential loss of information due to the limitations of the medium, difficulty discussing sensitive issues and impacts on patient-clinician relationship, empathy, and compassion[7,8]. An additional burden is witnessing increased emotional stress felt by sick in-patients due to current restrictions not allowing their family to be at their bedside often right up to the time of death. The need to manage patients with a life-threatening illness and/or advise on the adverse effects of treatment without the diagnostic accuracy and confidence of seeing the patient in person can make the interaction more mentally challenging for the clinician. Face-to-face communication by video is not really just face-to-face. As clinicians, we are trained to read nonverbal cues from the whole bodies of our patients to have a better understanding of their situation and what they are communicating to us[9]. It also serves as a validation of their understanding of what we convey to them. During a video visit, the frame is often limited to only a person’s face, therefore eliminating access to many of these nonverbal cues[7].

In addition, consulting with patients is not simply exchanging information. Not being able to hold a patient’s hand or hug them after delivering bad news hinders certain therapeutic elements associated with touch or interpersonal communication for both the patient and provider [9,10]. The clinician’s sense of job fulfillment is also related to the human-to-human connection embedded in trust and sincerity from our patients, and this is one of the main reasons most of clinicians went into medicine in the first place [11]. As telemedicine visits will likely continue at higher than pre-COVID levels after the pandemic, we need to be cognizant about its effect on clinician burnout and career fulfillment.

THE END OF THE GLOBAL MEGA-CONFERENCE AND A MOVE TO MORE ELECTRONIC LEARNING

Possibly a double-edged consequence of COVID-19 has been the rapid demise of the multinational cancer mega-conference in its usual format. The environmentally destructive impact of bringing thousands of oncologists from across the globe to a single city has often been ignored[12]. The focus was on increasingly exuberant meetings with pharmaceutical company funding at its core. Academic groups and pharmaceutical companies have found ways to work around the restrictions on travel induced by COVID-19. With improvements in technology and teaching techniques can there really be any future for the global cancer mega-conference even if widespread COVID-19 vaccination is effective? We are all going to need to embrace online learning and that can be challenging. However, reduced pharmaceutical company requirements for such conferences could hopefully lead to more “Key opinion leaders” with less pharmaceutical company influences – we suspect sadly this is unlikely to happen. While these conferences provided a welcome break from the stresses of cancer care and the opportunity to socialize with colleagues, the inefficiencies and cost of global travel (including quarantine processes), and the likelihood that the pandemic will continue globally for several years, will undoubtedly curtail conference related travel indefinitely.

REGULATORY ISSUES AND THE RISE OF THE ELECTRONIC MEDICAL RECORDS (EMR)

With looming deficits exacerbated by the pandemic, more government involvement in the Canadian health-care system is imminent as they search for possible cost savings. With changes in EMR where more and more work is loaded onto the physician, many are laying off support staff. Physical examinations are already done less frequently – to the detriment of the diagnostic (and therapeutic) value of thorough examinations. An attempt to overhaul the fee system in Alberta in 2019 (put on hold due the COVID-19 pandemic) led to 87% of Alberta doctors making changes to their practices, including lay-offs, reduced hours, early retirement and possibly leaving the province [13].

Since our original article, EMR’s have been adopted widely and have added to the complexity of patient care. While their intent is to increase efficiencies in quality of care, they are oftentimes less than intuitive and are often designed for around inpatient work, making their adaptability to an outpatient practice less than ideal. They have led to increased documentation requirements, computerized ordering with routing of prescriptions, a never-ending inbox as what were formerly perceived as clerical tasks are now off-loaded to clinical staff. leading to physicians spending more time on a computer than they do face to face with patients[14].

In a cross-sectional survey of 208 physicians and learners, 74.5% of those who reported burnout symptoms identified the EMR as a contributor[15]. It is therefore not a shock to hear that EMR implementation has an impact on retirement rates. Those at the cusp of retirement may see

this as an unplanned opportunity to transition to the next phase of their life, rather than learn a new system. A retrospective study investigating medical provider attrition at a major academic center found a peak in provider attrition in the month prior to EMR implementation[16]. Indeed, at one of the authors' centers we still talk about a senior surgeon standing up in the middle of one of the many compulsory evening/weekend teaching sessions on the new EMR and saying, "That's it, I am done. Time to retire" and walking out of the room. We have it on good authority that he remains very happy with his decision!

NOVEL THERAPEUTICS IN ONCOLOGY

The pace of innovation of treatments in medical oncology is faster than ever before. It is now more difficult to stay abreast of the new research and maintain competency. Oncologists need to dedicate even more time to stay up to date with current literature and those at or near retirement age may be reprioritizing their life away from attending medical meetings and reading medical journals and more towards other obligations. The rapid evolution of immunotherapy (and its often perplexing toxicities) and precision oncology are two examples. Again, this feeds back to a need for us all to evolve to improved learning strategies. As oncologists, we have all had to learn to evolve – indeed this was often one of the most satisfying parts of our job, quite simply learning about new treatments that enhanced the outcomes of our patients was pleasurable.

SO WITH THESE CHANGES, ARE MORE ONCOLOGISTS CHOOSING TO RETIRE?

Today despite anecdotes that more physicians are choosing to retire early, we were unable to identify whether or not this is true. This is important as an exodus of senior oncologists could present significant challenges to the health care workforce as medical oncology demand could exceed supply. Indeed, ASCO predicts a shortage of 2,393 oncologists by 2025[4]. Such an exodus could present significant challenges for all involved in health care and more investment should be put into workforce planning and resource management[4]. This could include incentives to oncologists pondering retirement, such as promoting a part-time transition, the increased use of nurse practitioners and advance practice nurses, as well as appropriate transitioning of patients back to their primary care providers[4]. More data is clearly needed. However, irrespective of when one chooses to retire, there are key steps that need to be put in place.

WHAT DO YOU NEED IN PLACE FOR RETIREMENT AND HOW DO YOU HANDLE RISK?

These issues were extensively discussed in our previous publication[1] but some fundamentals remain the same (Table 2). As always, proper retirement planning should start early and be ongoing throughout one's career, as the needs of the young newly qualified oncologist with young children varies greatly from the 60-year-old with no

mortgage, but who needs to provide for adult children and elderly parents. Savings should begin early for all physicians in order to retire with a good standard of living at a reasonable age. The first step is to try to determine a precise required retirement income. As we previously discussed, it is commonly recommended that one should save enough to draw 70% of pre-retirement annual earnings to maintain a similar lifestyle. Whether this 70% cut off really applies when we are at the top of our earnings should probably be questioned. The next step is to understand the risks associated with different income sources, creating a road map for modeling and reviewing final retirement plans. This is all best done under the guidance of an experienced financial advisor to help you develop a personalized and comprehensive financial plan. All physicians should have an up-to-date will, advanced directive planning and power of attorney documented. Estate planners are also being recommended earlier on, to help bring family members into decision-making processes.

While incentives to retire have changed amid COVID-19, so too has the financial environment. The current pandemic has led to a significant economic slowdown as lockdowns shut down many businesses and unemployment rose in certain sectors. In response, interest rates were lowered which has a direct impact on the person planning for retirement or currently in retirement. They are living off their savings (i.e. a "fixed-income") derived in large part from the interest generated from their savings and investments. Previous generations were both more inclined to save as they lived through hard economic times more than once and valued passing on an inheritance more than current generations think they will. As income generated from savings declines and life expectancies increase, the strain of low interest rate policy is placed squarely on the shoulders of the prudent saver and those dependent on their savings to fund their income. The low rates we are seeing today significantly decrease the sustainable income that can be received from one's savings and they also create less incentive for savers to put more money aside as the reward of doing so has been decreased.

The TINA effect (There Is No Alternative) has been created by low interest rates and increased longevity. This has led to the demand and need for this generation to move funds from now lower yielding fixed income instruments to riskier speculative investments in the stock market. This has shifted the risk spectrum away from a more conservative asset mix to a more aggressive approach. Unlike their younger counterparts, retirees do not have time on their side to recover from potential negative market fluctuations. This approach goes against the typical advice of reducing the risk of one's portfolio as one approaches retirement. They are assuming more risk in doing so but, as the moniker infers, they do not have any other choices. Furthermore, inflation and the prediction of increased federal taxes coupled with increased longevity will also exacerbate finances leading to possible riskier investments.

Another "risk" retirees face today is the paradoxical risk of increased longevity. Rightly or wrongly many financial advisors assume that the retiree's life expectancy will increase to 95. In order to sustain an after-tax income of

CAD \$90,000 per year, they would now require non-registered savings of CAD\$2,324,000, an increase of CAD \$802,000 or 53% more than if they live to age 85. When preparing for financial independence one needs to consider what additional savings would be required to be prepared for this increased longevity, including the thoughts of care in one’s later years. These additional costs include caregivers, care programs and private care residences. Should daily home visits be required for a loved one or oneself, this would set you back approximately CAD\$ 45,000-55,000/year for 7 hours daily, and that is without the increase in price due to the current pandemic. Provincial care programs for patients with dementia despite government coverage still require CAD\$ 25,000-30,000/year out of pocket.

Not only this, but current retirees are often seen as a sandwich generation, needing to provide for both their elderly parents and their adult children. This has been exacerbated by COVID-19 which has led to a disproportionate economic impact on young adults with the highest proportion of American children aged 18-29 living with their parents since the Great Depression[17]. There is also a question of how this economic slowdown will affect young adults achieving typical milestones such as completion of their education, buying a house amid higher housing costs and beginning their own family. Navigating the economic reality of the past year has been a challenge even for those who are financially savvy and in tune with the market. As such, more than ever, a seasoned financial advisor is essential for achieving the desired lifestyle throughout retirement.

IS CONTINUING TO WORK BEYOND AGE 65 A GOOD THING?

For physicians, working past 65 is often seen as a good thing. We spend years of training to be fortunate enough to be able to care for others in a stimulating and exciting field. Those near, at or beyond the age of retirement not only have years of experience but more importantly, hold wisdom that can be passed on to the new generation of aspiring physicians. Their role as mentors is invaluable and should not be discounted. As such, implementing a gradual transition into retirement with de-escalating responsibilities can benefit both parties. Physicians working at institutions with flexibility leading to increased access to sabbaticals, flexibility of working hours and control over career development are known to delay retirement[18]. De-escalation of clinical responsibilities over a period of time allows medical oncologists to extend their careers and provide the benefit of their experience to a system that will find specialist physician resources in short supply. For example, as noted above, the demand for medical oncologists is only going to grow [4].

On the other hand, delaying retirement may lead to one’s golden years passing them by and can have two adverse consequences. First, is the issue of excessive workload and burnout which were frequently cited reasons for retirement and are more common with increasing age [18-20]. A study in 2013 showed that almost half of oncologists were burnt out, thus revealing that one must often take moments to introspect on one’s work-life balance

throughout practice and make necessary modifications[21]. This has been exacerbated by the current pandemic with a recent survey by ESMO of the global oncology workforce during the COVID-19 pandemic showed an increase in respondents experiencing burnout feelings from 38% in April-May 2020 to 49% in July-August 2020[5]. Handling an excessive workload coupled with sleep deprivation, threats of litigation, and witnessing human suffering may become more challenging after 30 years in practice. The second consequence is that one is getting to an age where they see the health of colleagues and family members deteriorate, evoking a lot self-reflection on priorities and leaving many wondering “why did I wait so long to retire?”

TRANSITION

Lack of clear retirement policies and recommendations for transition out of practice has led to less than seamless transitions and many physicians feel that transitioning into retirement is not as easy process[22]. Many find it tough to go cold turkey after dedicating so many years to medicine, especially during a pandemic. It is possible to continue contributing, by reducing hours, shifting from patient care to research, mentoring or global oncology. While part-time work is attractive, many practices do not accommodate it as de-escalation leads to higher workload for other practice members[22]. Some physicians might move to less alluring work such as doing locum work in smaller centres, working in the pharmaceutical industry or with insurance companies, government agencies, chairing committees or working in a poorly paid overseas job or medically underfunded areas. While everyone seems to want to travel after retirement – in the post COVID-19 world this may be neither possible nor plausible therefore the focus on recreational activities is even more important. A good hobby should be fostered prior to retirement.

WHAT ABOUT YOUR COLLEAGUES?

With market demand expected to exceed supply of oncologists in the future, it is clear that retirement is not only affecting the retiree but will be leading to increase workload for their colleagues[4]. This is why strategies for a smooth transition of practice is necessary now more than ever: scaling back on-call hours, stopping new patient entry and sharing patient care with the incoming practitioner are all policies that have been used however most centers do not have clear retirement policies[23].

IS THERE LIFE AFTER RETIREMENT?

Most physicians struggle with their sense of self after retirement, as they lose a part of their identity that made up so much of their life. This loss can also be felt as a separation from the health care system and a loss of the protection that it provides. Many stressors are non-financial, with up to 27% of retired physicians exhibiting some signs of depression[24]. Despite these factors, retirement is still seen as an overall positive experience and has been known

to lead to improved overall health and improved quality of familial relationships[25].

CONCLUSION

Paul McCartney was 16 when he first penned the song, "When I'm Sixty-Four." Did he realize back then that he would still be working well into his 70s? Oncology, like the music industry, requires passion for a demanding career that is surrounded by emotional distress. It can also be incredibly rewarding, and despite our love of our work, we should all be planning for a future beyond full-time oncology. Amid the current pandemic, oncologists are not alone in taking a step back, looking at their life goals and reprioritizing. COVID-19, technological advancements in patient care, and the shifting economic climate has likely changed people's retirement plans. The advice of a highly qualified financial planner has probably never been more important. They can help model the impact of lower investment yields and longer life expectancies so you can be prepared and adjust your plans well in advance. The prudent individual looks well into the future and makes their plans based on the information at hand. When the situation and variables change, so does the plan.

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There exists a paucity of current literature and resources for retirement planning and transition. It is clear that prospective studies are needed, especially with the predicted growth of the field and shortage of oncologists in the future. We hope this paper will remind physicians that they will not live forever and that they should not ignore financial management. With proper planning and more than a little luck, let us hope we will all be able to make a successful transition, under our own terms.

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A.H.P. is still dreaming of as happy retirement on his boat but if he were to live to 90 can't quite afford it yet. M.J.C. would simply like to believe his children will one day leave home.

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Brent Vandermeer: CrossPoint Financial – iA Private Wealth, No financial relationships

Ian Gunstone: Financial Advisor, No financial relationships

The other authors indicated no financial relationships.

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Table 1. Evolution of issues around retirement in 2021 (Adapted from [1] with permission)

	2013[1]	2021
Issues addressed:		
When do Oncologists tend to retire?	Average age of retirement 65[2]	More data required
How long do doctors live?"	Average age of physician death in the past 20 years is 77 years across all specialties [1,26]	Average age of death is likely to increase in the future[1,26]
What Do You Need in Place for Retirement?	Planning should start early and be ongoing throughout one's career	Likely more capital is required to sustain the same income due to lower yields on investments and higher volatility in markets.
How Do You Handle Risk?	Asset allocation depends on individual circumstances but should be based on one's risk tolerance and proximity to retirement	Depending on portfolio mix, higher risk tolerance may be required due to the TINA* effect or adjusting to lower income expectations.
Is Continuing to Work Beyond Age 65 Necessarily a Bad Thing?	Identify flexibility in work hours Burnout increases with age	Challenges of maintaining competence, adapting to EMRs and changing models of care. Greater awareness of illness and death in your colleagues and family members
Transition	Start planning your interests for after retirement – BEFORE you retire! Choose your model – cold turkey vs. more gradual transition	COVID-19 will make any future planning challenging, including wishes for travel
What About Your Colleagues?	Consider reduced on-call hours, crossover period of "shared care" between the outgoing practitioner and the incoming practitioner. Remember your colleagues will notice if you are not pulling your weight!	Systems should be more open to job sharing to try to lessen the impact on colleagues in the future. Demand for medical oncology services predicted to exceed supply of oncologists
Is There Life After Retirement?	Retirement is not only about financial losses. Being a physician is a large part of self-identity. Depression is common Focus on: exercise, personal well-being and family!	No change from before.

TINA (There Is No Alternative): impact that low interest rates have had on the income a saver can generate today versus when rates were higher. These savers are moving out the risk spectrum to generate higher yields or to use capital gains to generate income because there is no worthy alternative that meets their needs.

Table 2. Retirement - Planning ahead (Adapted from [1] with permission.)

AGE BAND	TASKS IN 2021
30-39	<ul style="list-style-type: none"> • Assemble a professional team of advisors (e.g. accountants, lawyers, financial consultants and bankers). • Get insurance (e.g., term life, potentially permanent insurance, disability, critical illness, long-term care). • Ensure portfolio is designed in accordance with personal risk tolerance, time horizon and to meet your specific goals. • Create a legal will and Power of Attorney documents, review it regularly and update it as necessary. Communicate wishes with Executor, Power of Attorney and Beneficiaries so all intentions are known and clearly understood.
40-49	<ul style="list-style-type: none"> • Pay off debt, lines of credit and mortgage • Accelerate wealth accumulation, maximizing tax-deferred retirement savings or retained corporate surplus to invest for long-term retirement needs and other goals • Monitor investments and asset allocation regularly to ensure they are in line with what you want your money to do for you. • Review insurance needs and ensure that risks are covered (death, disability, longevity risk, and long-term care) • Do estate planning: use of permanent insurance to maximize your estate, to potentially provide income in retirement and to reduce taxes
50 INTO RETIREMENT	<ul style="list-style-type: none"> • Meet regularly with your financial consultant to update goals, the topics noted above, and retirement projections • Have regular decision-making meetings with family – including end of life wishes! • Track (in detail) annual expenses and review your budget regularly • Review pension plans and tax-deferred retirement vehicles for expected income