Update and short version of the Report on retention of doctors in their “third age” for Health Workforce New Zealand
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Note
The Report was developed for HWNZ by Sue Ineson of Karo Consultants Ltd

The full Report was developed in May 2011 and is available from HWNZ. An updated Section 6 was added in September 2011.

Implementation of the Report’s recommendations started in August 2011.

This work is now being extended to other health professional workforces including nurses, midwives and some groups of allied health professionals.
1. Executive summary and recommendations

Health Workforce New Zealand’s (HWNZ) plan has as an objective “to improve the capacity of the medical workforce to meet service demands”. This includes developing and implementing recruitment and retention strategies.

HWNZ has also drawn attention to the challenge of meeting future health care needs due to the increasing demand on health services as the population ages. The medical workforce is also ageing. Added to this, older doctors are working fewer hours and many are retiring earlier. The result is a growing concern about increasing shortages in the Senior Medical Officer (SMO) workforce.

However, as life expectancy of doctors is similar to that of the general population, doctors are living longer and therefore their period of retirement has lengthened. If doctors are retiring at age 60 or earlier and have a life expectancy of approximately 75 - 80 years, the individual may have 15 or more productive years to contribute in some way to medicine.

This presents an opportunity for HWNZ to encourage doctors to remain in active practise longer and/or contribute to medicine in different ways in their “third age”.

Reasons for retirement

An initial review of literature shows that the reasons for retirement include:

- Readiness for retirement and desire to have interests outside medicine
- Lack of job satisfaction
- Concerns about doctors’ health
- Concern about decline in technical skills and physical abilities with age.

Ways to encourage contribution to the work force in the third age

There is limited discussion in New Zealand on how to influence and if possible delay the retirement age of doctors. Literature on retirement of doctors and information from Medical Colleges in New Zealand indicates that the following strategies can be used to encourage doctors to continue to contribute safely to medicine. These include:

- Increased career exit planning and mentoring in the latter stages of a doctor’s career
- The development of readily accessible measures of cognitive changes related to aging so that decisions about time of retirement from practise are based on objective information, so if they continue to work they can do so safely
- Enabling those in the latter part of their careers to change work focus such as decreasing interventional work, reducing caseload or case type, retraining in other specialties and doing locum work
- Providing opportunities for more flexible ways of working including; working consistent shifts, decreasing on call and night shifts, part time work and job share positions
- Changes in work roles providing opportunities for work in medicine outside clinical practice
- Improving career satisfaction
- Decreasing any regulatory barriers to doctors continuing to work in medical practise.
More research and workforce modelling is needed

There are gaps in current research that need addressing, including:

- Why retirement rates differ across the different non surgical / non interventional specialities and why they differ in the same speciality in New Zealand and Australia
- Whether older doctors do go overseas for different lifestyles or do locum work in their later years
- The retirement intentions of generations of X and Y and IMGs
- On future workforce trends and modelling how the desire for younger doctors to have increased work life balance could be dovetailed with retaining older doctors in the workforce working more flexible hours
- How other professions are dealing with the challenge of retaining people in the workforce longer.

Recommendations from the original Report

- HWNZ use forums with the profession and health leaders to raise awareness about how doctors can safely extend their careers.
- HWNZ use their website to give advice on “third age” career options including guidance about career flexibility and career changes. The website could also give information on doctors willing to mentor older SMOs.
- HWNZ set up an area on their website where non clinical roles in medicine can be posted with guidelines on what skills and knowledge the roles require.
- HWNZ and DHBs should work with doctors nearing retirement so all SMOs have an career plan for their last years of work which includes exit strategies and plans for work after medicine.
- DHBs and other employers should include end of career planning when re-credentialing older doctors, including discussions on succession planning, flexibility of job size, work hours, case load and case type choices, job sharing and career changes such as retraining options and locum work.
- HWNZ explore the feasibility of funding retraining for doctors in other non interventional specialties (bonding the doctor for a period following the retraining) as an investment in the future workforce.
- HWNZ work with the Medical Council and Colleges to develop accessible measures of cognitive changes related to aging to assist objective end of career decision making.
- HWNZ encourage the Colleges or CMC to develop guidelines on the safe minimum number of hours to be worked in the specialty, if they are in management or advisory roles.
- HWNZ encourage Council of Medical Colleges (CMC) to develop common guidelines on working safely and appropriate shifts for older SMOs.
- HWNZ encourages the Colleges to develop common modules of training across specialities and a common approach to recognition of prior leaning (RPL) to enable career/speciality changes “in the third age” to be facilitated.
- HWNZ, DHBs and Colleges actively encourage older doctors to be more involved in teaching trainees and interns – to be “listening teachers”.
- HWNZ, DHBs and Colleges actively encourage older doctors to take on roles in medicine after they leave active clinical practice.
• HWNZ work with others such as RCMA or the New Zealand Centre of Excellence in Health Care Leadership to encourage the development of courses for up-skilling doctors wanting to take on non-clinical roles.

Discussion is needed now on how to influence and if possible delay the retirement age of doctors so they can continue to safely contribute to medicine in the latter stages of their career, as this will address help meet increasing demand on health services as the population ages.

Work achieved to date

• HWNZ representatives have started to use forums with the profession and leaders in the health sector to raise awareness about how doctors can safely extend their careers.
• Information has been prepared for the website to give advice on “third age” career options including guidance about career flexibility and career changes. The website will promote career exit plans for doctors in their later years of work and guidelines on the safe work hours/safe shifts and work practices for the older doctor. Information will also be posted about a range of non-clinical roles with guidelines on what skills and knowledge the roles require.
• The website will include case histories that feature doctors’ experiences of alternative ways of working such as being more involved in teaching, working part time and part year, job sharing and to give guidance on being a locum especially in general practice.
• Discussions have been started on the use of credentialing committees to assist older doctors think about succession planning, flexibility of job size, work hours, case load and case type choices, job sharing and career changes such as retraining options and locum work.
• Research has started on the possibility of a simple tool that could be used to assess measures of cognitive changes related to aging to assist objective end of career decision making.

2. The problem

Recruitment and retention of doctors in New Zealand is being addressed by various strategies by HWNZ. This Report explores the need to retain doctors in their older years within the medical workforce by encouraging them to be involved in clinical practice longer and/or to contribute differently to medicine in their “third age”.

An Australian study noted that “retirement will place unprecedented pressure on the medical workforce and policy makers face a critical challenge to ensure workforce needs are met over the next 20 years1”. Therefore policies and incentives to “encourage ongoing employment among older clinicians, albeit at reduced hours, are crucial”.

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Another Australian study on workforce predictions from 2001-2012 noted that “lower retirement rates and doctors staying in the workforce longer, would result in a significantly larger workforce, particularly in the short term2”.

Both studies agree retirement rates are a key determinant of workforce supply.

Currently doctors are retiring earlier; those in the workforce are getting older and are working fewer hours. These changes are exacerbated by feminisation of the workforce as generally women doctors work fewer hours and retire earlier.

Data showing these changes is in Appendix 1. Concern about earlier retirement of doctors and the aging of the medical workforce has been noted by commentators and many of the specialist Colleges, as it is considered this will exacerbate current workforce shortages.

Most commentators assume doctors will continue to retire earlier. This may not be correct. Many other people are now working longer as their life expectancy is increasing. If doctors can be encouraged to work longer albeit for fewer hours per week, in different specialty areas and/or in different roles, workforce supply may not decrease as fast as predicted.

As their period of potential retirement is longer, doctors will be faced with:

- A longer time when they need a meaningful purpose to life.
- Ways to ensure their retirement savings are sufficient and can withstand economic downturns.

Doctor retiring in the near future will have to consider their choices but most lack a definitive plan for the latter stages of their lives. Advanced planning can lessen the “shock of the transition from the working phase to the retirement phase of one's life”3. This planning should include when to decrease or stop active practice and consideration of all the alternatives to full active practice.

3. Scope of the project

The full Report:

- Briefly canvassed reasons why doctors retire.
- Gave an overview of current workforce data in this area.
- Outlined regulatory matters.
- Developed some initial solutions to improve retention of older doctors.

The Report also gave details on the literature that was reviewed and comments from the specialist Colleges. Most of the larger colleges responded in some way and many expressed interest in the research.

To forward ideas raised in the Report a meeting was held with policy staff from the specialist Colleges, staff from the Medical Council and NZMA to test the ideas, conclusions and recommendations in August 2011 and several general practitioners were asked for ideas after an article in the RACGP e-Pulse newsletter.


3 Cronan, J. J. “Retirement: it's not about the finances!” 2009.
4. Reasons for retirement from the literature

Research notes that the main reasons for doctors to retire are age restriction in some jobs are:

- Readiness for retirement.
- Job satisfaction.
- Concern about decline in technical skill.
- Health concerns.

4.1 Age restrictions

Literature reviewed notes that in some positions doctors over a certain age are not able to work. Other articles encourage specialties and Boards to set a retirement time noting that entry to the medical profession is rigidly specified but exit or retirement is not. Therefore it is argued there is a need for guidance about voluntary retirement especially for the operative specialties.

Human rights law in New Zealand does not allow an age to be used as a reason to preclude a person from a position and there is no compulsory retirement age. That said, the Medical Council and all specialist Colleges should have strategies to ensure those doctors in active practice remain competent and those working in non clinical roles, advising and teaching are up to date with practice. Some specialties overseas are beginning to develop policies in these areas.

4.3 Readiness for retirement and what to do after retirement

Some doctors are more ready to retire than others. Like the general population doctors age at different rates. Reasons why doctors do not want to retire include:

- Financial security.
- Concerns about boredom after retirement.
- The need for continued self-fulfilment.
- The sense of worth gained from work.
- Regarding work as a place for social interactions.
- The intellectual stimulation gained from work.

Other doctors advocate for alternative lifestyles outside of medicine and easing into retirement. Using the latter stages of one’s career to go back and do things that were precluded during a busy medical career “to go back and explore a road not taken.”

Male and female doctors have a different approach to retirement planning. Women were more likely to work part-time and less likely to work past age 65 years. Male doctors’ retirement decisions are influenced by having adequate income, the age of any dependants, personal stress, burnout or health issues including the health status of their spouse and their

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other interests. Female doctors considered other expected income, adequacy of retirement income as well as age, stress, burnout and the availability of part time work\(^5\).

Management in health services and workforce planners need to consider the reason why doctors do or do not retire and adapt SMO job descriptions and positions to enable older SMOs to work more flexibly and thus remain in practice longer. This may include encouraging older SMOs to:

- Continue to consider more working shorter hours, reducing shift and on call work.
- Decrease case load or case type.
- Have time out for alternative activities.
- Take on different roles in medicine.

### 4.3 Job satisfaction

Several studies echo the reasons for retirement given in the article *Old Surgeons never die*\(^6\) these include:

- The impact of increased administration.
- The threat of medico legal proceedings.
- Increasing complexity of medical technology.
- The advent of newer techniques.

The concern about the “system” was considered to be a disincentive to staying in the work force by several commentators from the United States. The most recent Royal New Zealand College of General Practitioners (RNZCGP) membership survey conducted in 2008, said factors most likely to influence future work intentions were:

- Lack of job satisfaction.
- Increasing paper work.
- High level of bureaucracy.
- Increasing compliance costs.
- Family considerations.
- Availability of locums.

Another study from the USA noted that, while “managed care” is an important factor in the retirement decisions of physicians, it does not necessarily lead to earlier retirement. Financial and personal issues were more important in making retirement decisions and these did significantly impact on doctors expected retirement age.

Knowing the reasons why doctors retire has implications for their own end-of-career planning and for planning ongoing service delivery for health care managers.

### 4.4 Concern about a decline in technical skills

Several studies, record doctors’ concerns that they may lose skill and competence as they age and therefore they retire, possibly earlier than they need to. Most of these studies relate

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to areas of surgery or emergency medicine where reactive time, dexterity, fine motor skills, endurance, and eyesight are crucial. There is interest in developing ways to assure older surgeons that they have the ability to continue to practice (that is they have the physical and mental stamina, coordination, reaction time, and judgment to provide appropriate care.)

A study on cognitive changes and retirement among senior surgeons noted that individuals age cognitively at different rates. The results showed that “expected age-related cognitive decline was demonstrated on all measures, although measured reaction time was notably better than age-appropriate norms.” The results suggest that although self-perceived cognitive changes play a role in the decision to retire, these are not related to objective measures of cognitive change. This is not a reliable basis for making retirement decisions.

Alternatively concern has also been expressed that some surgeons fail to recognize the effects of aging, which may place their patients and themselves at risk. Both personal and institutional problems can arise when surgeons continue to practice despite limitations of aging. These doctors would also benefit from the development of methods for evaluation of performance that reflect a surgeon's response to aging.

The development of readily accessible measures of cognitive changes related to aging may serve to assist objective end of career decision making.

4.5 Health concerns

In one study, retirees rated themselves in significantly poorer health than working psychiatrists, even when age was taken into account.

In a study of retired GPs a total of 35% scored above threshold for significant psychological distress, and the higher psychological distress the earlier GPs wanted to retire. In New Zealand in the most recent RNZCGP membership survey conducted in 2008 noted that poor health due to aging, illness, exhaustion, work related stress and burnout were factors likely to force future working intentions.

A change in work focus, time out or job size may assist aging doctors to continue in medicine and to remain in good health but this takes active career planning.

5. Summary of issues for specific specialties

In the Medical Council 2009 workforce survey the specialties that have doctors with the highest average age are dermatology at 51 years, medical administration (53 years), musculoskeletal (56 years), occupational medicine (53 years) and palliative care (51 years). The average age of doctors working in the surgical specialties ranged from 45 to 47 years.

Many of the articles refer to specific surgical specialties as this is where age related impairments and specialties that require on call and long shifts which are also difficult for the older doctor.


In New Zealand few of the Colleges have researched the impact of doctors working in “their third age”. Some have noted clinical and safety concerns of an ageing workforce. Other Colleges have raised concerns about doctors moving to alternative advisory roles but getting “out of date” because they do not work any hours in active clinical practice.

5.1 Australasian College for Emergency Medicine (ACEM)

In emergency medicine one of the reasons given for FACEMs to consider retiring or changing roles is long antisocial shifts. It is argued that it is better for doctor and the patients if on call and night shifts stop once an emergency medicine doctor reaches 50 years old.

Guidelines for emergency physicians produced in the USA to prolong careers include:

- Looking at workplace modifications to minimise or eliminate rotating or night shifts.
- Scheduling older physicians to have:
  - Dayshifts in the week end instead of night shifts.
  - Consistent shifts at set time of day or night – to minimize circadian disruption.
  - Additional time off after night shifts.
  - Shorter shifts if possible to less than 8-10 hours.
  - Fewer consecutive shifts.
  - Shifts where patient volumes and acuity of work is matched to the pace of senior physicians.

Like other interventionist specialties, FACEMs should be aware of their limitations as they get older so that there are no patient safety concerns. The literature notes that doctors in this specialty have flexibility because the relationship with patients is not ongoing, so older FACEMs may be able to:

- Decrease work hours.
- Take on new roles.
- Take time out.

5.2 Royal Australasian College of Medical Administrators (RACMA)

RACMA has noted that a significant group of older specialists move into medical administration. RACMA has an older group in the standard training programme. These tend to be clinical directors or senior advisors in health related agencies. RACMA has an accelerated training pathway for senior specialists. This career change may be to give the doctor another challenge rather than a strategy to delay retirement.

5.3 Australian and New Zealand College of Anaesthetists (ANZCA)

The College has noted anaesthesia specialists will drop out of the workforce at the time there is a need for more anaesthetists due to changes in demographics in New Zealand. Measures are needed to enable anaesthetists to work beyond 65 years and this could include older doctors restricting their work to pre-assessment clinic work or only selected cases in theatre.

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5.4 Royal Australian and New Zealand College of Psychiatrists (RANZCP)

An Australian RANZCP study showed that most psychiatrists continue to work until later in life, with only 18% retiring before 65 years of age. Research also notes that those aged over 50 work fewer hours. The RANZCP study has noted that “perhaps 1 in 16 women and 1 in 8 men might work till they are 70 years”.

Members of the College noted that local retirees seem to come back intermittently for locum positions in times of shortage. Lifestyle factors are increasingly importance for all doctors.

5.5 Royal Australasian College of Physicians (RACP)

The issue around aging of the profession is currently informally being debated within RACP. Currently 17.1% of physicians are under 40 years with the largest cohort, 30.4% of physicians being between 40 and 49 years of age, 28.1% are between 50 and 59 years old and 24.4% are over 60 years.

This is a different age profile to surgeons, as shown in the RACS study where only 10% of surgeons were over 60 years. This is probably due to the different nature of clinical practice.

5.6 Royal Australasian College of Surgeons

A 2008 CTA report on workforce forecasting noted that the workforce needed to increase by 2.2% per annum until 2026 to meet need. Pediatric surgery was the only sub speciality, where demand was not increasing as this population was declining. There is scope in some sub specialities to limit work to office based work and performing minor procedures at an older age as dexterity or stamina declines.

The College notes a significant proportion of surgeons change their pattern of work, ceasing or reducing clinical involvement during the final phase of their career. Some surgeons do continue in advisory roles, leadership such as CMA roles, administration and medical reporting. The College does a regular activity report with information on retirees i.e. when doctors have moved from activities that include involvement in medicine, surgery, medico-legal work or other specialist non-procedural and non-clinical work such as surgical administration and academia.

5.7 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The RANZCOG has noted the aging and feminisation of their workforce, with 46.2% women, of which 72.3% are in the 41-60 age groups and 15.3% over 60 years. The majority worked on call at least one night a week and overall night work/ on call is given as a reason for retiring.

Reasons for retirement were consistent with other research - that is age, cost of medical indemnity, medico legal concerns, lifestyle, health, family, difficult meeting CPD requirements and other matters such as a move to medical management, career change hospital politics and disenchantment.
5.8 Royal New Zealand College of General Practitioners (RNZCGP)

The most recent RNZGP membership survey conducted in 2008 gained input from 52% of the profession (1799 doctors). A fifth of the respondent General Practitioners (GPs) intend to retire in the next five years.

The study indicates that:

- GP work fewer hours from the age of 56 - 60 years, with an average time spent working of 50 hours a week.
- This decreases to 34.8 hours per week for those still working when they are over 70 years. Over this time the doctor tends to increase the amount of the time they spend directly consulting with patients.
- Those in the 56 - 60 year age group spend 58% of their time consulting with patients.
- Those over 71 years spend 72% of their time on patient consultations.
- Average income decreases as age increases and there is an increase in preference to doing locum work.

Doctors from other specialties do move into general practice after having worked in another scope. Currently, as vocational registration is not required to work in general practice in New Zealand, there is no requirement for these doctors to undertake retraining to work in this speciality.

Some GPs work in other roles such as teachers, assessors or reviewers in their later years. The membership survey notes non general practice medical work took 3.8% of hours per week; education of other health practitioners took 1.4 % and collegial supportive roles at 5% hours per week.

The membership survey also notes that since 2005 that there has been a seven fold increase in the number of GPs who have moved to management positions, such as positions in DHBs and PHOs.

5.9 College of Intensive Care Medicine

The College of Intensive Care Medicine Fellowship Affairs Committee has recently established a project looking at the issues surrounding provision of consultant Intensive Care Medicine services by “elderly” specialists. This work is in the preliminary stages. The College is attempting to address the issues of provision of an acute specialty, requiring complex time critical decision making , much of which is provided in the out of office hours, by elderly practitioners.

In addition to long hours of service, increasing resource limitation issues and limited after-hours collegial support have been identified as factors that potentially put the elderly practitioner at increased risk.

5.10 Royal College of Pathologists of Australasia and New Zealand (RCPANZ)

The RCPANZ data notes that in New Zealand currently about 16% of NZ pathologists are in active practice are over 60 years of age with 6% over the age of 65 years. In Australia by comparison, three years ago the figures were 20% over 60 years and 10% over 65 years. In 2010 this had increased to 23% and 12%.
New Zealand pathologists seem to retire earlier than their Australian counterparts but no data exists that may explain the reason for this.

The RCPANZ prefers that pathologists in active practice fill most College roles. This should be active practice in the sub specialty most relevant to role of the committee or working group.

5.11 The Royal Australian and New Zealand College of Radiologists

The Radiology Workforce Survey Report 2010 which is currently in draft notes that:

- Since 2000 the number of radiologists in New Zealand has increased by 40%.
- The average age of radiologists in New Zealand is 51.4 years (in 2000 it was 46.6 years).
- The proportion of female radiologists is increasing with 27.7% female in 2010, up from 24.3% in 2000.
- The mean retirement age was 66.7 years whereas in 2000 it was 63.8 years showing that radiologists are remaining in the workforce longer.
- Two thirds of respondents said they were involved in teaching and supervision.
- More flexible work arrangements would encourage those who have or those considering retirement, to remain in the workforce.

5.11 Speciality overview

There is a wealth of information within the Colleges about when and why doctors retire and ideas on what could encourage doctors to remain in clinical practice or do other roles. No one group is collating and bringing together all this information to advise the profession or employers on future trends and developments.

HWNZ could work with the Colleges or the Council of Medical Colleges (CMC) to:

- Develop guidelines on the hours of clinical practice a doctor requires to be effective in a managerial or advisory role.
- Develop similar guidelines on employment hours and shifts for older SMO
- Formalise ways doctors trained in one speciality may re train in another
- Devise common modules of learning and common approach to RPL.

6. Regulation and the Health Practitioners Competence Assurance Act 2003 (HPCAA)

The HPCCAA requires Responsible Authorities to assess applicants who have not held an annual practicing certificate within the last three years. This may act as a barrier for doctors who have retired to return to the workforce in another role. The other potential barrier for doctors who wish to change speciality or move into non clinical practice is the need to recertify and maintain competence.

All vocationally registered doctors in clinical practice have to be involved in recertification programmes. Several comments from the Colleges noted the difficulty for older doctors to maintain recertification requirements, especially if they were working part time. However it
may be necessary for part time doctors to do more Continuing Professional Development (CPD) to ensure competence and public safety.

Doctors working in non clinical roles need to have a current annual practising certificate (APC)\(^{10}\). If they are registered in a vocational scope of practice, limited to non clinical practice, they may recertify by participating in their College recertification programme. Most of the Colleges now include CPD programmes and activities targeted for those in non clinical practice. An alternative is to join and participate in the Royal Australasian College of Medical Administrators recertification programme.

If a doctor is registered in a general scope of practice they will need to recertify by having a collegial relationship with another doctor and putting a CPD plan in place.

Alternatively a doctor may apply to Council for approval to have a CPD associate that is another person familiar with and competent to do the work you are doing. For example if you are serving on a Board or Committee it may be a Chair, fellow board or committee member. This person does not have to be a doctor.

The retired doctor on a low income may also be able to claim a reduction in the cost of the APC fee or a waiver of the APC fee if they are giving service to the profession. Thus the current Council policy does not act as a barrier for older doctors moving to other roles.

7. Solutions

There is limited discussion in New Zealand on how to influence and if possible delay the retirement age of doctors. If doctors are retiring at age 60 or earlier and have a life expectancy of approximately 75 – 80 years, the individual may have 15 or more productive years to contribute in some way to medicine.

Increasing focus on strategies to retain doctors in medicine is needed now.

HWNZ should use forums with the profession to raise awareness about how doctors can safely extend their careers. The forums should discuss strategies to help doctors to continue to contribute to medicine in their “third age”; encouraging doctors to work in active clinical practise for as long as they are safe and how they can contribute to medicine in different ways. Discussion also needs to take place on how to assist doctors move from active clinical practise into other roles if they are no longer coping or are not safe.

7.1 Career and succession planning

Research indicates only 50% of doctors actively plan for retirement. Doctors need to plan so they are able to decide how:

- Long to remain in active clinical practice.
- To increase flexibility in the way they work so they can work longer.
- To find out about other medical roles.

\(^{10}\) A doctor is practising non-clinical medicine if engaged in such activities as:
- medical informatics,
- contributing to medical media,
- teaching to members of the profession and students (without direct patient contact), research not involving humans,
- medical advisory, board or some committee work.
• To develop other interests outside the job to ease adjustment into retirement.

They may also need advice to ensure their financial planning is sufficient for their needs as the literature has noted some doctors continue to work because they need an income. These "retired-on-the-job" doctors need to be encouraged to develop other interests and counselled out of the job.

HWNZ has set up a system that requires trainees to have career plans at the start of their career – this concept could be adapted for doctors in their "third age".

This may include working with doctors to change their mind set. It has been noted that doctors are usually "instinctively decision makers" who like to be "in charge". These attitudes mean that doctors may exclude themselves from alternative jobs or roles as they have concerns about taking on a lesser of position without first considering the possible advantages.

HWNZ and DHBs should work with doctors nearing retirement to look at developing an “exit” career plan for their last years of work.\(^{11}\)

HWNZ has also made a commitment to ensure trainee’s access to mentors to assist them in decision making early in their career. Research indicates that SMOs later in their careers also need advice on increasing work flexibility changing career focus and taking on new roles.

HWNZ could use their website to give advice on “third age” career options including guidance about career downsizing and career changes. The website could also give information on doctors willing to mentor older SMOs.

Doctors and their managers should be encouraged to develop succession plans in each department. This needs to include strategies to have others to take over some of the work load as older SMOs reduce job size. These discussions could start during the re-credentialing processes for doctors over 55 or 60 years so there is time to ensure continuity of workforce. In the USA, the most favoured policy option for regulating the age when doctors can work was by hospital privileging bodies. Investment in career exit planning would be more effective than accepting that many doctors stop practice suddenly due to ill health or disenchantment.

When re-credentialing older doctors, DHBs and other employers should discuss career exit planning, succession planning, flexibility of work hours, job sharing and retraining options.

Some research has noted that doctors will respond to incentives to remain in the work force. This incentive may be money, where maintenance of income with fewer hours may be more important that more income per se. It may also be assistance to retrain or have periods of breaks to refresh them. Financial incentives in the form of increased pensions were most attractive to those already planning later retirement.

HWNZ could explore the feasibility of funding retraining in other specialties with the doctor bonded for a period following the retaining.

\(^{11}\) As HWNZ has noted career planning has benefits for everyone and that international evidence suggests that sound career planning processes will benefit both employer and employee.
7.2 Access to readily accessible measures of cognitive change

The main reason for not keeping older doctors in the workforce longer is the concern that they may not be safe and competent to practice. Older age does not inevitably preclude cognitive proficiency. Self-perceived cognitive changes do play a role in the decisions to retire, but these are not necessarily related to objective measures of cognitive change.

The development of readily accessible measures of cognitive changes related to aging may serve to assist decisions either to continue clinical practice or to retire.

HWNZ could work with the Medical Council to develop tools to measure cognitive changes. If available these tools could be used by employers when credentialing older SMOs. There may be potential to work with other agencies such as the National Patient Assessment Agency in the United Kingdom. (Work on assessing cognitive changes in the airline industry could be used as a model).

7.3 Doing different work within the career specialty, retraining and locum work

Some older doctors reduce their involvement with interventional medicine and do more office based care, move to other specialities, or take up locum positions.

Doctors may also move from one specialty to another. A barrier to movement is the current requirement in most Colleges to start retraining from the beginning of the training programme. Some Colleges like RCMA do have a policy that recognises prior learning leading, if the candidate is successful, to an accelerated pathway. Most Colleges have moved to competency based training, with a requirement for a certain number of hours in clinical practice. More common training modules across Colleges and recognition of required learning would assist doctors look for new challenges in different specialties or move to a speciality with fewer physical demands.

Acting as back up physicians or doing locums is an opportunity for older doctors who require virtually no training.

Colleges should be encouraged to develop common modules across specialities and a common approach to RPL and to enable career changes to be facilitated.

HWNZ support for retraining could be a good investment.

7.4 Work force flexibility: part time work, job share and portfolio lifestyle

Many of the comments about workforce from the differing specialties noted that doctors in their older years want to work part time. This is seen as negative as it reduces the FTEs available to deliver health services. However research has indicated the option to work part time would have the most impact on keeping some working past the age of 65 years. Job share positions may decrease the need for locum coverage of acute services.

Using flexible work hours, job share, work breaks and other strategies to keep older doctors in the workforce is a better investment than accepting full retirement.

Therefore managers should help their senior SMO to plan to downsize their workload over time, especially moving away from on call, long or rotating shift work and nights. These new strategies may dovetail well with the desire of generation Y to have a better work life balance. For example where could be a trade off, where older doctors work part time and
accept weekend shifts, as they should be more able to organise family and leisure commitments in other times of the week. Older SMO may be freer to travel to deliver services throughout the region.

In terms of patient safety older doctors need to know when their performance may be impaired due to their age (this is discussed in Section 7.3). They should be encouraged to review the case load and case type or move to office based practice so they stay within their competence and age based limitations.

HWNZ should work actively with employers and the Colleges to develop advice on how job size and working hours can be adapted to enable older doctors to remain clinically active and thus remain in the workforce longer.

7.5 Changing work roles

Doctors, as with other groups in society, will require continuing intellectual stimulation for longer. This means other roles can be developed such as sharing their knowledge through teaching.

In a study at least 50% of those surveyed would have accepted some form of teaching if it was offered. The article noted that while the older surgeon may not be “well versed in the minutiae of the latest surgical research they did have a wealth of experience to pass on”. Of those surveyed 43% stated they would have accepted part time work if it had been offered.

Teaching such as on grand rounds or mentoring younger doctors can be an opportunity and one that is easier as the retired doctor does not have appointment schedules and constraints on their time. The possibility of a new role being a “listening teacher” for trainees assisting the over worked SMO by being able to spend more one to one time with the trainee, doing mock viva, act as a passive assistant in a theatre situation and be able to give advice including when to call the surgeon responsible for the patient. As teaching is a privilege therefore the “listening teacher” must:

- Be willing to listen to what is being asked of them by the prime teacher and deliver on this – not what they believe should be delivered.
- Be loyal to whoever asks them to assist in teaching and not undermine the doctor who is the prime teacher.
- Ensure they do not see the role as an opportunity to promote their own reputation but use their experiences to guide trainees – who may learn more from the “past disasters that the past glories”.
- Accept the role is for a fixed time period which if it is working on both sides can be renewed.

The important message in this article – is that management and other doctors may not wish to ask older doctors for help as they may feel they may not be able to set the parameters of the role and end the relationship when the time to do this comes. A job description, fixed contract period and training in the new role can help to overcome this reluctance.

There are also other roles where medical knowledge is required such as:

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• Assisting with recertification and re-credentialing.
• Working as medical advisers or assessors or on statutory Boards for DHBs, PHO and other health groups.
• Writing medical legal/insurance reports/reviewing medical claims.
• Research, writing articles and editing work.
• Assisting with performance reviews and/or up-skilling doctors for organisations like the Medical Council.

Currently in New Zealand there is an informal process to fill these roles and often it is via advice from senior clinicians who do not have in depth understanding of the health system, health politics, health finance, health economics or health law. There is no process to identify those with skills and no place where these doctors can find about these roles and gain skills in the areas of medical leadership, management and governance roles. RACMA or the New Zealand Centre of Excellence in Health Care Leadership could take on this role.

HWNZ could set up an area on their website where non clinical roles in medicine can be posted with guidelines on what skills and knowledge the roles require.

HWNZ work with others to encourage the development of courses for up-skilling doctors wanting to take on new roles

7.5 Improving career satisfaction

Being tired of the administrative and bureaucratic factors of medicine may encourage doctors to retire. Work life balance is being increasingly valued: this may not mean fewer hours spent in medical pursuits but it may mean fewer hours spent in direct patient care.

Ideas that could encourage doctors to remain active in practice and encourage later retirement include:

• Reducing administrative duties, and improving managerial support.
• Interventions to reduce stress.
• Financial incentives in the form of pensions were attractive to those already planning later retirement.

8. Increased research is needed in specific areas

There is limited New Zealand research about the intention of doctors with respect to retirement and what would keep them in practice. More information is needed to be able to do longer term workforce modelling and to align the needs of younger doctors wanting work life balance and portfolio lifestyles with more flexible working conditions for older SMOs.

Further research in the following areas would be useful:

• Are SMOs leaving NZ in their later years?
• Will the next generation of doctors have the similar retirement plans?
• Will younger female doctors continue to work fewer hours for shorter periods?
• Why do different have different retirement rates?
• Will the large number of IMG working in New Zealand have an impact?
9. Conclusions

There is limited discussion in New Zealand on how to influence and if possible delay the retirement age of doctors. Doctors need to plan the latter stages of their career so they can

- Negotiate a change work focus such as decreasing interventional work, reducing caseload or case type, retraining in other specialties and doing locum work.
- Develop more flexible ways of working including; working consistent shifts, decreasing on call and night shifts, part time work and job share positions.
- Move from interventional specialities to office based medicine or reduce case load or change case type or decide when they should retire from active clinical practice.
- Retrain in other areas of medicine or other specialities.
- Find alternative work roles in non clinical medicine and maintain career satisfaction.

This requires focus across the sector and more research in some areas.

Sue Ineson
Karo Consultants Ltd
Appendix 1 - Statistics relating to age and the workforce

1. Size of the medical workforce

From 2005 – 2009 the medical workforce grew by 14.7% due to the increase in the number of female doctors (by 8%) and the increase of IMGs (by 23.7%). This has resulted in a greater number of doctors per head of population while enabling the number of hours worked to remain steady at 44 – 45 per week. Average age has increased slightly from 44 to 45 years of age over that time as shown figure 1.

*Figure 1 Changes in the workforce*

<table>
<thead>
<tr>
<th>Facts at a glance</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of the medical workforce¹</td>
<td>11,578</td>
<td>12,283</td>
<td>12,643</td>
<td>12,949</td>
<td>13,269</td>
</tr>
<tr>
<td>Doctors per 100,000 population²</td>
<td>283</td>
<td>297</td>
<td>299</td>
<td>303</td>
<td>307</td>
</tr>
<tr>
<td>Proportion of women (%)³</td>
<td>36</td>
<td>37</td>
<td>38</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Average age of workforce (years)³</td>
<td>44</td>
<td>44</td>
<td>45</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Average weekly workload (hours)³</td>
<td>46</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>44</td>
</tr>
<tr>
<td>Proportion of International Medical Graduate (%)³</td>
<td>38</td>
<td>40</td>
<td>38</td>
<td>39</td>
<td>41</td>
</tr>
</tbody>
</table>

¹ Based on medical doctors registration data at 31 March each year.
² Based on registered medical workforce data and Statistics New Zealand’s estimated resident population.
³ Based on data from annual medical workforce survey of active doctors. Source: Medical Council of New Zealand.

2. Doctors in the workforce are getting older

The Medical Council 2008 workforce report graphed the age distribution of doctors in the workforce over the last thirty years.

In 2009 the largest group of doctors was in the 45-49 age group. In earlier years 2000 the largest group of doctors (almost 20%) was in the 40-44 age groups. In 1990 the largest group of doctors was in the 35-39 age groups. Some of these changes are due to the increase in numbers of doctors being trained.

*Figure 2: Age distribution of the active workforce (1980–2009)*

Source: Medical Council of New Zealand
The Medical Training Board reviewed the current information available to it in 2008 and noted that the forecast retirement path of the current stock of doctors if compared with the “continuing flow of medical school graduates, at the level established from 1982 to 2004 in the next decade there will be significantly more additions to the medical workforce than retirements to it. However, this trend will decline in the following decade to the extent that in the third decade the number of retirements will match the number of additions.”

**Figure 3: Additions to registered medical doctors compared with retirements and other losses – replacement of current New Zealand graduate doctors 2011–2055**

Since the report of the MTB the number places in medical schools have increased and this will impact on the MTB predictions. In 2008 the MTB noted that their projections are based on 285 medical graduates per annum. Changes to the medical school cap in recent years should eventually produce 365 graduates per annum.

**Figure 4: Vocational training completions and retirements**
An ASMS\textsuperscript{14} paper notes that in 1998, 24\% of the specialist workforce was over 55 or over by 2008 that had increased to 28\%. The SMO commission notes this drop in number may reflect the smaller number of students 30 years ago, but also may reflect loss of SMOs due to retirement, career change, or leaving NZ to practice medicine overseas.

3. **Doctors are working fewer hours**

Doctors are now working fewer hours; the average hours worked by all active doctors in the Medical Council 2009 survey was 44.7 hours, in 2004 it was 45.8 hours and in 1997 it was 48 hours. Average hours worked decreases for doctors between 30 and 44 years of age and then increases slightly till it declines after 60 years of age.

A study on the ‘newer generation’ of doctors showed an ‘emphasis family and lifestyle’. Therefore these doctors ‘were less likely to work long hours and accept unpaid overtime’ and ‘lifestyle factors and working hours influenced the doctors’ choice of training.’\textsuperscript{15}

4. **Women doctors retire earlier**

The number of women in the medical workforce is also increasing with 46\% of women in the workforce under the age of 40 years compared to 28\% of men. Only 4\% of women are in the workforce over the age of 60 compared to 16\% of men.

The impact of feminisation is greatest in general practice as 34.1\% of women trainees are training in this specialty, internal medicine is the specialty that is the next most popular for with 12.4\% of women trainees.

*Figure 5: Age distribution of the active workforce by gender*

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure5.png}
\caption{Age distribution of the active workforce by gender}
\end{figure}

Source: Medical Council of New Zealand

\textsuperscript{14} Association of Salaried Medical Specialists. “State of Specialist Workforce Crisis in New Zealand Public Hospitals.” 2010.
Appendix 2 - References used in compiling the full Report


Royal New Zealand College of General. Royal New Zealand College of General Practitioners 2008 Membership Survey. Wellington:


