



# Phased retirement, retraining, and role reversal

Rainer H. Borkenhagen MD CCFP FCFP

Is retraining practical when you are close to retirement? This is the question I considered after 36 years as a family doctor in Vancouver, BC. I was semiretired and ready for a change of scene and pace for my final 2 to 3 years of clinical practice. Seeking challenge, flexibility, and adventure, I was also yearning to experience rural practice again, where I had started out. My wife and I packed up and moved to Gibsons, BC, on the Sunshine Coast, known for its mountains, old-growth forest, waterways, and beautiful beaches. I wanted to get acquainted with, and help out, its medical community, as well as some of the more remote BC and Canadian towns.

### Readying for retraining

I had done hospitalist work 10 years earlier, and up until 2 years before our move, had periodically supervised residents on an inpatient ward. However, to fully prepare myself for the BC rural locum program, I completed the advanced cardiac life support course, spent 2 weeks with the trauma service, practised intubations and inserting intravenous lines under the supervision of the anesthesia department at a large teaching hospital, and spent time in an emergency department with a colleague.

Shortly after our move, as I was strolling along the beach, I chanced upon Simon Reznick, a young family physician. Eleven years earlier Simon had been in his first year of medical school, where I had mentored him as part of a program run by the Faculty of Medicine. We stopped to chat and I learned he was now a well-established full-service practitioner in a clinic with 4 or 5 other doctors on the Sunshine Coast. We talked about rural locum opportunities. I explained I felt a bit “rusty” as a rural physician because over the years my practice had evolved into an office-based urban practice in adult medicine. We discussed the 1-month retraining program the BC Ministry of Health offers to urban physicians to upgrade their skills for rural settings.<sup>1-2</sup> Simon and I agreed to apply. We were about to reverse our mentor and mentee roles and curious to see how it would work out.

### Reversing roles

On the first day we met at St Mary's, a 39-bed family physician-run hospital located in Sechelt, the seat of the Sunshine Coast. Dr Reznick had admitted a patient the evening before, following a housecall, faxing in the history and orders remotely. In an urban setting, this would have been impossible. We visited a pregnant patient who was 37 weeks along with mild preeclampsia, for nonstress fetal monitoring. We toured the hospital, including its 4-bed intensive care unit and 8-bed

emergency room, and Simon introduced me to his colleagues and the hospital staff. We went to his office and he showed me how to navigate their electronic medical record (EMR) system; my practice had been paper-based.

By the first week's end we had done 3 emergency shifts together and spent many hours in his clinic with patients. He has a complex, full-spectrum load, from obstetrics to palliative care. The patient with preeclampsia ended up having a cesarean section, which he invited me to attend at 5:30 AM and which was complicated by low Apgar scores that necessitated short-term ventilation and intravenous support for the newborn. I developed a deep appreciation for his thoroughness.

During the month in Dr Reznick's clinic, I encountered an experience common to residents and locum physicians. It is one thing to analyze the patient's presenting problem and review his or her history and the related investigations to come up with a plan of care. It is another thing to know the complex mix of background issues surrounding the patient's problem that a longitudinal care relationship allows. A short-term locum physician seldom plumbs that depth of understanding.

The January 2012 issue of *Canadian Family Physician* focused on the aging physician,<sup>3-6</sup> describing the “double-edged sword” of increasingly efficient diagnostic skill involving pattern recognition, countered by age-related decline in analytic reasoning skills.<sup>3</sup> As the days went along, I found I was confronting this situation. Current neuroscientific evidence assures me I haven't lost too many brain cells,<sup>7</sup> but Dr Reznick's synapses seemed more active, and he seemed to have more robust neuronal networks as a computer-adept multitasker.

However, current research on brain plasticity and aging encourages developing new skills instead of repeatedly using acquired ones.<sup>8</sup> And so, instead of limiting my activity to what I knew best, and slowing down in activities that require rapid cognitive processing (as in a busy hospital emergency department), I was trying to develop reasonable competence in some things I hadn't done for 20 years or more. Exposure to emergency care and a broader patient spectrum were going to be essential.

### Observations

Although I enjoy emergency work, I now know I no longer have the bounce-back of a younger physician following an all-night shift, and that my processing skills slow down after 11:00 PM; hence, within locum work in rural practices, taking on busy emergency shifts with high patient volume is likely unwise for me.

I also acknowledge as valid the habit of pattern recognition as one ages, and the tendency to limit one's differential diagnoses a bit prematurely. These habits are a form of confirmation bias, whereby we mentally discard symptoms that do not "fit" and focus on those that support the presumed diagnosis. Similarly, they also show "overconfidence bias," too heavy a reliance on intuition. Dr Reznick kept his possible diagnoses more diverse. In this particular rural setting, more narcotics were prescribed for pain, and more joint or bursal injections given, than I was used to. These therapies are part of a setting where many patients work in resource industries and do heavy physical labour.

In my city practice, I became used to recognizing some patterns of obscure symptoms as likely benign and found that temporizing could be a useful therapeutic intervention. Dr Reznick was apt to investigate more fully or treat early, particularly in the emergency department, where most cases called for investigative and therapeutic action, and sometimes before adequate histories were even available.

### Coastal collegiality

There was a good level of collegiality among the coastal physicians, more than I experienced as a physician in Vancouver. For a community of 30 000 people, with many retirees, there are about 30 family physicians (not all full-time equivalent) in 5 independent clinics. All had purchased the same EMR system software with a remote server, although there is as yet no direct link between clinics for one common EMR patient database. The hospital emergency department is staffed by these same physicians, who also make themselves available in a number of other on-call scenarios, including anesthesia and surgical assists. In-hospital patients on the weekend are attended to by a rota of "second on-call" physicians, who are also the backup for the emergency department if the physician on duty gets swamped. Finally, older physicians have been allowed to give up their emergency shift obligations.

For my mentor, Dr Reznick, this month's rotation with me prepares him for taking on family practice residents.

He went out of his way to include me in unique clinical cases and to facilitate my learning objectives, particularly in the areas of radiology and emergency medicine. In return, I subsequently made myself available for a month's locum in his clinic.

### Closing comments

This experience is evidence that an aging professional can indeed retrain to a certain level of competence. I have since certified in advanced trauma and pediatric life support and spent time in pediatric emergency. There is a role for a semiretired physician to play in



a rural practice—a role perhaps not full-on but diverse enough, with some emergency work, to keep things operational during a vacation respite. But it is sobering to sense one's slowing down. I now function best with regular routines and time for reflection. For an aging physician, the challenge is to sense the tipping point of one's resilience and competence. In the

meantime, more than anything, the month of retraining allowed me to understand the possibilities open at this stage in my career. For new learning, however, one needs enough context to consolidate it. I have since done 1- to 2-week locums in interior and coastal BC, as well as Canada's Arctic, and am enjoying the challenge. 🍂

**Dr Borkenhagen** is Clinical Assistant Professor in the Department of Family Medicine at the University of British Columbia and on staff at Providence and Vancouver General hospitals.

#### Competing interests

None declared

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