Esther Choo, President of AWAEM requested that members of AWAEM who have been involved in leadership positions in academics and leadership be assembled to discuss the topic of ‘slowing down’ towards the end of a successful career. Members of the group included Diane Birnbaumer, Michelle Biros, Michelle Blanda, Kathleen Clem, Gloria Kuhn (Moderator), Libby Nestor (Recorder), Sandy Schneider, and Ellen Weber.

In the discussion it became apparent that each of the members had been thinking about this issue and all had realized that this was uncharted territory with no guides, recommendations, or suggestions as to how to gracefully transition to a new reality. As Sandra Schneider noted, “we are the first cohort of women emergency physicians facing retirement. We will, whether we wish it or not, be the role models for women emergency physicians who will shortly be contemplating transitions in their careers, such as slowing down, changing careers or retiring. We must get this right. We must be the trailblazers for this new phase of career.” Rather than being daunting, this statement both focused the group to the challenge of providing thoughtful comments based on experience, surveying women emergency physicians facing the same issue, and reviewing the literature on this topic. It also energized these women, used to being high-achievers, to tackle a new challenge.

This article will report the results of their discussion and plans for future activities by this group.

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Uncertainty: Concerns and Questions
Each of us, perhaps for the first time, is facing uncertainty regarding the future. Few fields are as structured as the career of medicine. College, medical school, and residency training are all highly structured. The uncertainty points of admission to medical school and choosing residency training fade away once acceptance has occurred; there are long periods of time where hard work focused on the desire to succeed supplant the need to examine the future. We realized that this might be the first time in our lives when we ask ourselves: “what do WE want to do? What are our goals? What will make us happy” instead of, “What is possible, given the constraints of academic medicine?” We felt that we were different than career-focused men whose identity is often tied to their careers and successes. But that may not be true. It’s a real paradigm shift for us - prior to this, job transitions meant moving UP from one position to the next, now we are contemplating ‘moving down or out’. Our practice and our involvement in academics continue to be very compelling to us. Are our jobs and personal identities inextricably intertwined? If that is so, how do we manage that unknown period of ‘after retirement’ or will retirement result in a loss of identity and a feeling of irrelevance?

One member acknowledged that leaving clinical work and ‘leaving the white coat in the closet’ was a frightening prospect. For women, accepting the reality of being a doctor, of internalizing the identity of being a physician is often harder and takes longer than it does for men. At the beginning of our careers we were breaking into a male-dominated profession that even questioned our very right and capacity to become competent physicians; men did not face these questions. Yet, perhaps all physicians fear the white coat in the closet syndrome; certainly all of us at the table acknowledged discomfort at the thought of not practicing clinically.

Not Just About Us
For those of us with partners or spouses, their transition is equally fraught with uncertainty. It may also be more complicated as we try to mesh the change in our status/job with a change in location that will ‘mesh’ with what our spouse/significant other is planning and needs in order to make the transition to this new reality a satisfying experience. And the transition for them and us depends a lot on financial planning that may or may not have begun many years ago. This led us to the acknowledgement that not all women physicians who will soon be retiring are equal financially.

Not all are the Same
Many of the discussants, but not all, came from institutions that had provided them with retirement plans that gave them financial options to fully retire if they chose that path. They also acknowledged that they were well known, allowing them to find new or different jobs in academics that might not be as stressful as what they were currently doing. Some, in fact most women in EM, don’t have a national reputation, nor the same range of options. Chairs may be looking to ease out the older, top dollar emergency physicians (in academic and non-academic settings) who are less and less interested in nights and may work at a slower pace. Many women and men EPs, lacking a paid faculty position in academics, (i.e. at a university or academic medical center) do not have defined pension benefits/health insurance options or benefits. The financial resources that will allow a comfortable lifestyle after retirement may be lacking or inadequate. It was pointed out that it is almost two separate problems: the older clinical female or male EP in a community setting with some academic responsibilities might be exchanging/reducing academic, administrative and outside activities, only to find herself, of necessity, in the more physically taxing job of shift work as a result of financial necessity.

Alternatives
We don’t want to give up all of our academic work and continue just working ED shifts, since we don’t want to be immediately irrelevant to the academic discussion. Indeed, we consider ourselves to be the ‘brain-trusts’ of our departments, not smarter but with longer institutional memory by virtue of being there longer. But how do our chairs afford to keep us on solely as teachers? Parenthetically, if we don’t work shifts will we be marginalized in teaching due to loss of credibility? We also agreed that Chairs should be encouraging/finding the new leaders among younger faculty. As painful as it might be, we need to make room for, and even welcome, new leaders who will replace us.

Methods of ‘slowing down’
Some might limit new projects that can be completed in a shorter time frame. Others will give up intense and stressful administrative positions to concentrate on research, perhaps becoming the director of research or the director of education. This provides a defined job and duties but is less stressful than being responsible for leadership of the department as chair.

Departmental Practices
Some departments have begun to create alternative tracks for physicians as they age while others have not.
• U. of New Mexico: retired people work 25% of the standard number of shifts, while getting paid 50% of their prior salary, indefinitely.
• Wayne State University: At Wayne, a similar arrangement is made, but can go on for 2 years only and is limited to those with tenure.
• UCSF: Many academic faculty have pensions and negotiated ways to reduce shift responsibility, but lose their ‘protected time’. At UCSF, for example, the standard shift load is 14/month; older academic EPs can work 8 shifts and get half-time salary and benefits, but very little ‘protected time’ for research, admin etc.
• Brown: Some academic places (Brown, for example) have only 401-type plans and no defined method to step down.
• LAC: At LA County, anything less than a 100% load = NO benefits Someone who retires from there can get full benefits indefinitely, encouraging retirement more than ‘slowing down’; some might choose retirement and then work shifts someplace else or take a completely different job in another academic department. That may be a loss to the original department.
• SUMA/Akron: Some groups have anticipated the problem, and although during the first 4 years at SUMMA/Akron new faculty are paid less, after 4 years all receive the same salary, so the senior physician is not unduly disadvantaging the junior faculty. There was no discussion of how the department handles a retirement package, provision of benefits, or benefits post retirement.
• Loma Linda: At Loma Linda, no full professors work nights, whatever their age. (That is the current agreement, though that group notes it is an arrangement that might not be feasible over time.)

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Annual Luncheon: Slowing Down, cont’d

Some departments are modifying types of work/shifts: Some groups modify the shifts that senior physicians do while others are beginning to question how or if work should be modified:

- Senior physicians are, for example, the most experienced people to have at Triage, to decide on ‘sick/not sick’, in a blink.
- Should departments stop senior physicians from doing certain shifts that have higher acuity or volume? Should they be prevented from doing certain procedures i.e. inserting central lines? How does this impact the physician who resents this curtailment of practice and is this even legal?
- Are senior doctors those we should utilize for our OBS shifts? The senior physician might be the perfect doctor to finish a prolonged work-up, arrange transition to other settings or continue to treat the asthma/COPD until discharge home. This would free up Urgent Area beds by placing those patients needing short term care into our 24/7 intensive treatment area.
- Are they the doctors to do follow up visits in a hospital area for the patient with no doctor, or the patient whose doctor can’t see them on the weekends?

Staying or Leaving

The advantage of staying in one’s own institution is that the territory is ‘known’, the system is familiar and available niches have been explored and entered. Colleagues have become friends. Our practice is very compelling to us, and in EM we tend to have more interaction with colleagues working at the same time - it is a practice characterized by camaraderie, and may be more difficult to leave than an office-based practice.

There are also down sides to leaving. In order to leave, one needs the energy involved in updating or restricting a CV, imagining the possible options for new careers, learning new skills, and perhaps facing rejection or failure. Starting a new career may be difficult. How difficult is it to become a consultant or a job coach? Should a senior physician consider employing a job coach/headhunter to aid in their own transition to retirement or new job/career? A new job may not be the answer. In another institution, you need to ‘prove yourself’ all over again and how eager are doctors at the new shop to welcome an older EP who may be slower due to new systems and age, not to mention the question of working a fair share of nights. How eager would another department be to create a position for an aging physician? What is fair? For example, do we make the newly retired Chair who loses academic funding, do 14-15 shifts/month? Can they do this even if they want to in order to retain their job?

Looking at the Future

As we neared the end of our discussion we questioned just how different is our situation from men and women in many fields facing the nearing of retirement. Perhaps we are just the newest constituency to begin to voice our concerns/needs/opportunities regarding a meaningful change in career related to retirement.

At the end of our discussion time, which ended all too soon, we agreed to form a taskforce to look at these issues. It really does not matter if many before us have faced these or similar questions and decisions. Nor does it matter if gender is not as much of an issue as we thought at the beginning of the discussion. What does matter is that all members of AWAEM will be involved in this decision making process at some point in their career.

Esther Choo has supported our desire to form a taskforce with Sandra Schneider as leader. For us, just talking about the issues, realizing that we all had similar questions and uncertainties, and knowing that we will be facing them together is both invigorating and comforting.

*Article approved by members of the discussion group.