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Review Article

Retirement After a Prolonged Career in Obstetrics and Gynaecology: Fulfilment, Transition, and Legacy

Olubusola Amu[1]*, Morounfolu Leye Thompson[2], Salwa Abu Yaqoub[1], Huda Abdullah Hussein Saleh[1] and Zeina Bu Shurbak[1]

[1]Women's Wellness and Research Centre, Doha, Qatar
[2]Al Wakra Hospital, Al Wakra, Qatar

***Corresponding Author:** Olubusola Amu, Women's Wellness and Research Centre, Doha, Qatar.

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Abstract

Retirement after a prolonged career in obstetrics and gynaecology is more than the cessation of employment. For physicians whose adult lives have been organised around clinical responsibility, unpredictable emergencies, surgery, teaching and close relationships with patients, retirement can alter identity, routine, social connection and purpose. Obstetrics and gynaecology adds particular complexity because the specialty spans birth, reproductive health, serious illness, surgery, loss and ageing, often creating professional relationships that extend across decades and generations.

This Special Article considers retirement from the perspective of the senior obstetrician-gynaecologist and examines professional fulfilment, sacrifice, late-career decision-making, health, financial independence, relationships, mentorship, succession and legacy. Current literature increasingly treats retirement as a developmental process rather than a single event. This perspective supports a gradual recalibration of professional and personal activities, with attention to meaning, wellbeing and the transfer of accumulated clinical wisdom. Financial preparedness is necessary but insufficient; psychological readiness, health, relationships and a credible life beyond clinical work are equally important.

Retirement should therefore be approached as the final developmental stage of a medical career rather than as professional disappearance. A thoughtful transition allows the physician to reduce responsibilities at an appropriate time, preserve valued relationships, transmit knowledge, broaden identity and enter later life with autonomy and purpose. For obstetricians and gynaecologists, influence may continue long after the final clinical encounter through patients, families, trainees, colleagues and institutions shaped by years of service.

Keywords: *Retirement; Obstetrics and Gynaecology; Physician Wellbeing; Professional Identity; Healthy Ageing; Mentorship; Legacy; Financial Planning*

Introduction

There is a particular finality to the idea of retirement in medicine. A physician may have spent more than three decades acquiring knowledge, refining judgement, accepting responsibility and becoming accustomed to being needed. Clinical medicine structures the day

and the week and, to a considerable extent, the physician's understanding of self. Leaving it therefore involves considerably more than surrendering a job title, closing a clinic or relinquishing a hospital identification card.

This is especially true in obstetrics and gynaecology. The specialty occupies an unusual position because its practitioners participate in events that are simultaneously clinical and deeply personal. An obstetrician may be present at the beginning of a life and, within the same working day, counsel another patient about pregnancy loss, infertility, cancer or major surgery. Gynaecological practice may extend from adolescence through reproductive life to menopause and later years. Long-term relationships can develop between clinician and patient, sometimes encompassing several generations of the same family.

The intensity of this work has consequences. Years of night duty, emergency calls, difficult decisions and responsibility for mother and fetus can create a powerful professional identity. The satisfactions are substantial, but so are the demands. Retirement may consequently bring relief and freedom while simultaneously producing an unexpected sense of loss.

Recent work on physician wellbeing conceptualises retirement less as a single event than as a process in which professional and personal activities are recalibrated while purpose and meaningful relationships are maintained [1]. Late career itself is increasingly recognised as a distinct stage of professional development, characterised by continued contribution as well as preparation for departure [2]. This moves discussion away from the narrow question of when a doctor should stop and towards a broader one: how should a physician complete a career well and enter the next stage of life with purpose?

This article examines that question from the perspective of a prolonged career in obstetrics and gynaecology. It is not intended to prescribe a universal model. Physicians differ in health, family circumstances, financial position, personality, professional opportunities and aspirations. Rather, the aim is to identify matters that deserve deliberate consideration before the transition occurs: fulfilment and regret, identity, competence, financial independence, health, relationships, continuing contribution, succession and legacy.

A professional lifetime in obstetrics and gynaecology

A long career in obstetrics and gynaecology provides an unusually broad view of human experience. It also provides a privileged view of how medicine itself changes.

A clinician entering the specialty several decades ago entered a different professional world from the one encountered by today's trainee. Diagnostic imaging was less sophisticated. Minimally invasive surgery occupied a smaller place in operative gynaecology. Reproductive medicine was developing rapidly but had not acquired its present scope. Electronic health records, digital communication, genomic medicine and contemporary approaches to clinical governance were either absent or at an early stage.

The social contract between doctor and patient has also changed. Earlier generations practised within a culture in which medical authority was rarely challenged and disclosure was frequently determined by the physician's assessment of what the patient needed to know. Contemporary practice places much greater emphasis on autonomy, informed consent, shared decision-making and explicit discussion of alternatives and uncertainty.

Senior obstetricians and gynaecologists have therefore done more than accumulate years of clinical experience. They have repeatedly adapted. They have learnt new procedures, abandoned others, revised clinical assumptions and accommodated changes in regulation, technology, litigation, patient expectations and professional culture. Such adaptation is easy to overlook when a career is assessed retrospectively. A curriculum vitae records appointments, qualifications, publications and leadership roles; it says little about the repeated intellectual adjustment required to remain clinically relevant over several decades.

The accumulated result is sometimes described as clinical wisdom. This is not synonymous with factual knowledge. A younger physician may know a guideline as well as, or better than, a senior colleague. What experience can add is the ability to recognise when the apparently straightforward case is not straightforward, when a deteriorating patient requires action before every investigation is available, when technically possible surgery is not necessarily wise, or when the most important intervention during a consultation is to remain silent and listen.

Such judgement is difficult to quantify and difficult to transfer through textbooks. Its loss is one reason why retirement has implications not only for the individual physician but also for departments and institutions.

The particular weight of obstetric and gynaecological responsibility

All branches of medicine carry responsibility, but obstetrics contains a distinctive form of uncertainty. Labour does not respect office hours. A pregnancy that has progressed normally for months can deteriorate rapidly. Decisions may need to be made within minutes and can affect both mother and child. Operative gynaecology carries a different but equally substantial burden: complex anatomy, haemorrhage, injury, malignancy, fertility implications and the knowledge that technical decisions may have lifelong consequences.

Over a long career, the obstetrician-gynaecologist accumulates memories that are not equivalent to ordinary occupational experiences. There are uncomplicated births remembered because of the joy surrounding them, but also catastrophic haemorrhage, severe pre-eclampsia, unexpected stillbirth, maternal collapse, neonatal compromise, cancer diagnoses and operations complicated by events that could not reasonably have been predicted. Some events remain vivid for decades.

The profession traditionally offers limited space for acknowledging the emotional residue of such experiences. Clinicians are expected to analyse the case, learn from it, communicate with the patient or family, participate in review and return to work. That resilience is necessary, but it should not be confused with emotional immunity.

A long career therefore contains an invisible history alongside its visible achievements. Retirement may create the first sustained opportunity to reflect on both. This is one reason why the transition should not be romanticised. A physician may feel profound satisfaction about a career while simultaneously carrying memories of patients who could not be saved, diagnoses that came too late, or clinical decisions that, with hindsight, might have been different.

A mature assessment of professional life makes room for these experiences. Fulfilment does not require a fictional career in which every outcome was favourable. Such a career does not exist. It requires the ability to distinguish responsible practice from perfection and to recognise that uncertainty is inseparable from medicine.

What does a fulfilled career mean?

Retirement encourages questions that may have been postponed during the busyness of clinical practice. Was the career worthwhile? Was the price paid by the physician and family reasonable? What was actually achieved? What will remain?

Medicine provides many conventional measures of achievement: qualifications, fellowships, publications, grants, professorial appointments, leadership positions, awards and invited lectures. These achievements matter, but they are incomplete measures of professional value. Ask an experienced clinician about the moments that gave a career meaning and the answer may be quite different. It may concern a woman whose life was saved after massive obstetric haemorrhage, a couple finally leaving hospital with a healthy baby after repeated pregnancy loss, a patient who returned years after successful surgery simply to say thank you, or a trainee who eventually became an accomplished consultant.

These experiences rarely appear in institutional metrics. The distinction between achievement and fulfilment becomes more important as retirement approaches. Achievement is often externally recognised. Fulfilment is internally experienced. A successful career may contain both, but they are not identical.

Recent discussions of physician wellbeing emphasise the importance of meaning in sustaining medical work [3]. This is particularly relevant to retirement because many external markers of professional status disappear rapidly after leaving practice. Titles may remain, but authority diminishes. Meetings continue without the retired physician. A successor occupies the office. New trainees may never have known the former consultant.

If professional satisfaction has depended principally on status, retirement can therefore be destabilising. If it has rested more broadly on contribution, relationships, mastery and service, its meaning is more transferable. The question becomes not whether one can reproduce the status of a consultant after retirement, but whether the values that made the career worthwhile can find expression elsewhere.

Achievement, sacrifice and the honest career narrative

Any serious discussion of a prolonged medical career must acknowledge sacrifice. The traditional structure of medical practice frequently rewarded availability. Senior doctors built careers through long hours, repeated examinations, relocation, research undertaken after clinical work, weekend duties and emergency calls. Obstetrics added the unpredictability of labour and acute complications.

The costs were not always borne by physicians alone. Partners and families accommodated disrupted meals, cancelled plans, night calls and holidays shaped around duty rosters. Birthdays, school events and family gatherings were sometimes missed because another family required the physician more urgently.

Retirement can expose these trade-offs because the professional urgency that once justified them has disappeared. Some physicians look back with satisfaction. Others experience regret. Many experience both. There is little value in rewriting the past as either heroic sacrifice or wasted opportunity. A more useful approach is to construct an honest narrative in which achievement and cost can coexist.

Regret can also be informative. Recognition that family life was sometimes subordinated to work may influence how retirement is lived. Time can be deliberately returned to relationships that previously received too little of it. A physician who postponed travel, friendship, creative work or community involvement may decide that these should no longer remain indefinitely postponed.

The aim is not to compensate mathematically for decades of professional commitment. That is impossible. It is to allow insight from the first part of adult life to shape the next. A coherent retirement narrative can acknowledge gratitude for the opportunities medicine provided while also accepting that professional success sometimes came at a personal cost.

Retirement and the loss - and expansion - of professional identity

Perhaps the least discussed difficulty in physician retirement is identity. The question “What do you do?” has had an easy answer for most of a doctor’s adult life. The answer carries social meaning as well as occupational information. Medicine provides community, vocabulary, routine and status. Colleagues understand experiences that can be difficult to explain outside the profession.

Retirement disrupts this structure. For some physicians, the change is immediately liberating. Others discover that they miss aspects of medicine they had assumed they would be pleased to leave: the intellectual challenge, informal conversations with colleagues, the satisfaction of solving a difficult problem or simply the sense that their presence mattered.

This reaction should not automatically be interpreted as inability to let go. It may instead reflect the predictable consequences of losing a role that occupied a large proportion of waking life for decades. Brower and colleagues describe retirement-related stress as shifting from occupational concerns towards challenges involving professional identity, health, relationships and loss [1].

The more useful objective is identity expansion rather than identity erasure. The retired obstetrician-gynaecologist does not cease to have been a physician. Professional experience becomes one component of a larger identity rather than its organising centre. That expansion is easier when it begins before retirement. Roles as spouse, parent, grandparent, friend, teacher, mentor, writer, traveller, volunteer, gardener, artist or community member should not have to be invented on the morning after the final clinical session.

Identity expansion also protects against the temptation to recreate a full medical workload under another name. Continuing professional activity can be valuable, but it is most sustainable when chosen rather than used to avoid confronting the transition itself.

When is it time to leave clinical practice?

The decision about when to retire is among the most difficult late-career decisions because chronological age alone provides an inadequate answer. Experience may improve judgement even as some physical and cognitive capacities change with age. The relevant question is therefore not simply how old the physician is, but whether he or she can continue to practise safely and effectively within the demands of a particular role.

This issue can be especially sensitive in procedural specialties. Major gynaecological surgery may require endurance, dexterity and prolonged concentration. Obstetric practice may involve overnight work followed by rapid decision-making in emergencies. A physician who remains highly effective in outpatient consultation, teaching or diagnostic work may reasonably decide that overnight obstetrics or complex surgery should end earlier.

Such modification should not be interpreted as professional failure. Insight into changing capacity is itself a component of professionalism. A staged transition may therefore be preferable to an arbitrary binary choice between full practice and complete retirement. Night duties may be relinquished. Operative workload may be reduced. Clinical sessions can decrease while teaching, mentoring or advisory work increases.

Evidence concerning physicians' attitudes towards retirement suggests that work satisfaction, health and burnout influence motivation to continue working [4]. The implication is important: decisions about retirement are not determined by age alone. The quality and sustainability of the physician's working environment matter.

There is also an institutional responsibility. Senior clinicians should have opportunities for confidential, respectful conversations about changing roles without assuming that age itself equals impairment. Equally, collegial respect should not prevent appropriate intervention where patient safety is genuinely in question. A dignified late-career culture must be capable of holding both principles at once.

Gradual disengagement and the value of a transitional period

Abrupt retirement may be appropriate for some physicians, particularly where health or personal circumstances require it. For others, progressive disengagement offers advantages. The purpose of gradual transition is not to postpone retirement indefinitely. It is to allow professional responsibility, identity and routine to change at a pace that can be psychologically and practically absorbed.

A senior obstetrician might first stop night duties, subsequently reduce operating sessions, then relinquish direct clinical responsibility while retaining teaching or mentorship. Another may leave clinical medicine entirely but continue with research, writing or professional society work. The appropriate sequence depends on the individual and the service.

This staged approach also benefits institutions. Succession becomes deliberate rather than reactive. Responsibilities can be transferred while the outgoing clinician remains available to explain their history and context. Junior colleagues acquire greater autonomy without losing immediate access to experienced advice.

The process requires discipline. Transitional arrangements can fail when the senior physician retains authority without responsibility or when the successor is given responsibility without genuine authority. Successful succession ultimately requires the retiring physician to allow others to lead differently. That can be one of the hardest acts of a distinguished career.

A transition also needs an endpoint. Without one, reduced practice can become indefinite practice, leaving both physician and department uncertain about responsibility. A clearly discussed timetable, reviewed when circumstances change, can preserve flexibility without allowing ambiguity to dominate the final years of work.

Passing on what cannot be found in a guideline

Modern medicine rightly values standardisation and evidence-based practice. Yet no guideline contains the entirety of clinical judgement. Experienced physicians hold substantial tacit knowledge: how to communicate grave uncertainty without destroying hope; how to recognise the deteriorating patient whose observations have not yet crossed an escalation threshold; how to manage conflict in theatre; how to recover a team after an adverse outcome; when to seek another opinion; and when persistence is appropriate but further intervention has become dangerous.

Late career provides an opportunity to make some of this tacit knowledge explicit. Mentorship is therefore not a ceremonial activity attached to seniority. It is an important form of knowledge preservation. Work on late-career physicians emphasises the substantial experience and wisdom that senior doctors can contribute to patients and colleagues while preparing for their own transition [2].

The best mentorship is not an attempt to reproduce the mentor. Medicine changes, and the next generation must practise in its own environment. The task is instead to transmit principles: intellectual honesty, technical discipline, humility, compassion, accountability and the ability to remain calm when circumstances become difficult.

Practical knowledge transfer can occur through supervised operating, case discussion, morbidity review, reflective teaching, simulation, leadership handover and informal conversation. Institutions should create time for these activities rather than assuming that expertise will somehow transfer itself.

A successful mentor should eventually become unnecessary. The most convincing evidence that knowledge has been transferred is not continued dependence on the senior physician but the confident, safe and independent practice of those who follow.

Financial independence: Necessary but not sufficient

Financial preparation is one of the most concrete aspects of retirement planning, and appropriately so. Retirement can last for several decades. Income may fall while healthcare, family and lifestyle costs continue. Physicians approaching retirement need a realistic understanding of pensions, investments, taxation, insurance, estate arrangements, expected expenditure and the effect of longevity on available resources. Professional financial advice may be appropriate, particularly where assets or pension arrangements are complex.

Yet financial readiness should not be confused with retirement readiness. A physician may possess more than enough money to stop working and still feel unable to retire. Conversely, a physician psychologically ready to leave may discover that inadequate financial preparation makes the decision impossible.

Financial independence is valuable because it restores choice. Once active clinical income is no longer essential, the physician can decide whether to continue working because the work remains meaningful rather than because stopping is economically impossible. This distinction can change the emotional character of late-career work.

Retirement planning should therefore begin with a question that spreadsheets cannot answer: what is the money for? For one person it may provide freedom to travel. For another it may support children or grandchildren, philanthropy, education, property, hobbies or simply the security of knowing that ordinary needs can be met without anxiety.

Accumulation without a conception of its purpose is not a retirement strategy. The financial plan should serve the life plan, not replace it. Equally, decisions about retirement should be based on realistic assumptions rather than fear. Understanding what is sufficient can be as important as continuing to accumulate more.

Health after a career spent caring for others

Physicians spend their professional lives advising patients to address risk factors, attend screening, exercise, sleep adequately and seek help when symptoms arise. They are not invariably good at following the same advice. Retirement creates an opportunity to reconsider health not as the absence of a diagnosis but as the preservation of capacity.

The World Health Organization conceptualises healthy ageing in terms of developing and maintaining the functional ability that enables wellbeing in older age [5]. This is particularly useful for retiring physicians because it shifts attention from disease counts to what an individual remains able to do and value.

Physical activity becomes important not because retirement should become another performance target but because mobility and strength protect independence. Resistance exercise, aerobic activity, balance, nutrition and adequate sleep become investments in future autonomy. Preventive healthcare, sensory health and appropriate management of chronic disease are equally relevant.

The same principle applies to cognitive health. Clinical practice supplies enormous intellectual stimulation. Removing it abruptly can leave a vacuum. Reading, writing, teaching, learning a language, studying history, playing music, travelling with curiosity or undertaking serious voluntary work can provide new forms of cognitive challenge.

Health also includes recognising limits. A retired physician is entitled to become a patient. Self-diagnosis and informal corridor consultations should not substitute indefinitely for ordinary medical care. Accepting appropriate care can be unexpectedly difficult for doctors who have spent their lives on the other side of the consultation, but it is part of adapting successfully to later life.

Psychological wellbeing and the permission to slow down

A medical career conditions people to respond to urgency. There is always another patient, another result, another meeting or another task. Retirement removes much of this externally imposed structure. Initially, an empty diary may feel like freedom. Later, for some, it begins to feel like absence.

The solution is not necessarily to recreate the previous workload under another name. Retirement offers something that clinical life rarely permits: the opportunity to decide which activities deserve time rather than merely responding to those that demand it.

A successful retirement need not be spectacularly productive. The physician who spent decades measuring value through output may need to learn that a day can be worthwhile without generating a clinic letter, operation note, publication or committee decision. This is not idleness; it is a different relationship with time.

Contemporary thinking about physician wellbeing recognises meaning and comfort as complementary dimensions rather than competing ideals [3]. A life consisting entirely of duty is difficult to sustain; a life consisting entirely of comfort may also become unsatisfying. Retirement allows a new balance between the two.

For some physicians, the transition may expose low mood, anxiety, loneliness or difficulty adapting. These experiences should not

be dismissed as weakness or treated solely as a problem of insufficient hobbies. Retirement is a major life transition, and appropriate professional support may sometimes be useful. Preparation can reduce avoidable disruption, but it cannot eliminate every emotional response to the ending of a long career.

Relationships after medicine

Professional life generates a large social network, but not every professional relationship survives retirement. This can be surprising. Colleagues who once spoke daily become busy with new responsibilities. Invitations diminish. Conversations change because the retired physician no longer shares current institutional problems.

Personal relationships therefore deserve deliberate attention before and after retirement. For physicians in long-term relationships, retirement may also alter domestic dynamics. A couple accustomed to one partner spending most days at work may suddenly share substantially more time. This can be welcome, but it requires adjustment. Retirement should not mean that one person's loss of professional schedule becomes another person's unwanted reorganisation.

Friendships outside medicine acquire renewed importance. So do relationships with adult children and grandchildren where applicable. Time becomes available, but healthy relationships require more than availability; they require attention without the expectation that decades of missed time can simply be reclaimed.

Social connectedness is an important component of wellbeing in later life. A retirement plan that addresses investments but ignores relationships is therefore incomplete. The practical question is not merely "Who will I spend time with?" but "Which relationships do I want to deepen, repair or create?"

Medicine can unintentionally narrow a social world because professional colleagues are always accessible and share the same language. Building relationships beyond medicine before retirement can make the eventual transition less abrupt and broaden the sources of companionship and belonging.

Meaning beyond clinical practice

One of the most persistent fears associated with physician retirement is the question: if I am no longer treating patients, what am I for? The question itself reveals how thoroughly medicine can become linked to usefulness.

Purpose, however, is not owned by clinical practice. The underlying values that drew many physicians to medicine - curiosity, service, problem-solving, teaching, compassion and responsibility - can be expressed in other settings. Some retired physicians continue teaching. Others mentor younger doctors, participate in research, write, serve professional organisations or undertake global and community health work. Some intentionally leave medicine behind and find meaning in family, agriculture, art, business, travel, faith, sport or civic life.

None is intrinsically superior. The essential task is not to find a substitute occupation with equal prestige. It is to identify activities that remain congruent with one's values. This distinction protects retirement from becoming another career competition.

The broader retirement literature suggests that interventions around the retirement transition often address physical activity, social participation, psychological wellbeing and lifestyle, reinforcing the idea that adjustment is multidimensional rather than purely occupational [6]. For physicians, this may mean intentionally constructing a week that contains relationships, movement, learning, contribution and rest rather than allowing one replacement activity to consume the space previously occupied by medicine.

Purpose can also be modest. It need not involve founding an organisation, writing a book or assuming another leadership role. Being reliably present for family, supporting a younger colleague, contributing to a community or pursuing a neglected interest may provide sufficient meaning without recreating the pressures of professional life.

Burnout, relief and the decision to stop

Not every physician reaches retirement after an entirely satisfying final decade. Increasing administrative burden, loss of autonomy, workforce pressures and changing healthcare systems may alter the experience of practice. Burnout is relevant because it affects both professional engagement and quality of care.

A large systematic review and meta-analysis involving 170 observational studies and 239,246 physicians found strong associations between physician burnout, career disengagement and adverse measures of patient care [7]. The findings do not mean that burnout determines retirement, but they illustrate why the emotional state in which a physician approaches the end of a career matters.

For some senior doctors, retirement therefore brings substantial relief. That relief should not invalidate the preceding career. A physician may have loved medicine while no longer loving the conditions under which medicine is practised. Distinguishing between the profession and the system surrounding it can be psychologically important.

Equally, retirement should not be used as the only institutional response to burnout in older physicians. Poor working conditions that exhaust senior doctors may also be damaging younger colleagues. The departure of experienced clinicians should prompt organisations to ask what knowledge and capability are being lost and whether aspects of the working environment contributed unnecessarily to that loss.

A decision made entirely in exhaustion may also feel different after a period of reduced workload. Where circumstances permit, modifying duties before final retirement can help distinguish a genuine wish to leave medicine from a wish to leave an unsustainable pattern of work.

Preparing the department as well as the doctor

Retirement is commonly framed as the physician's private decision, but senior departures can have substantial organisational consequences. A consultant may hold responsibilities accumulated informally over decades: knowledge of why a service developed in a particular way, relationships across departments, understanding of previous adverse events, specialist technical skills or the trust of colleagues who seek advice in difficult cases.

If this knowledge disappears on the final working day, succession planning has failed. Departments should identify essential responsibilities well in advance and distinguish those that need formal transfer from those that should simply end. Successors need time to develop confidence. Opportunities for joint working can help, provided they do not prevent the incoming clinician from establishing independent authority.

The retiring physician has responsibilities here as well. One of the final tests of leadership is whether the service can function without its former leader. A career that has built something worthwhile should aim to leave it capable of surviving its builder.

Succession also has an emotional dimension. A successor will not make every decision in the same way. Services evolve, teams change and practices once associated with the retiring physician may be altered. Resisting every change can turn legacy into obstruction. A more generous approach is to transfer the underlying purpose of a service while allowing its future form to belong to those who inherit responsibility.

Departments can support this process by recognising late-career contribution explicitly, planning handover early and avoiding the common pattern in which retirement is discussed seriously only when a departure date has already been announced.

Legacy: What actually remains?

The word legacy can sound grandiose when applied to an individual career. Yet every long medical career leaves one, whether intentionally or not. Some legacies are visible: a service established, a department developed, research published, a surgical programme introduced or a clinical pathway redesigned.

Others are almost impossible to document. A trainee learns how to speak to a bereaved family by watching a consultant do it well. A junior surgeon adopts a meticulous operative habit demonstrated years earlier. A patient whose life was altered by successful treatment raises a family. A colleague remembers being supported after a serious complication and later offers the same support to somebody else.

These effects travel through people rather than institutions. For this reason, legacy should not be confused with fame. Most physicians will not be remembered by the profession indefinitely, nor should that be the measure of a worthwhile career.

The more meaningful question is whether people and systems were better because the physician was there. If the answer is yes, the career continues to have consequences after retirement even when the physician's name gradually disappears from institutional memory.

Legacy also includes conduct. How a senior physician leaves can influence how colleagues understand professionalism. A graceful transfer of responsibility, generosity towards successors and willingness to celebrate the achievements of younger colleagues may be remembered as clearly as earlier clinical accomplishments. The final years of a career therefore contribute to legacy rather than merely documenting it.

A practical framework for the final years of practice

Preparation for retirement is best begun before a retirement date has been fixed. Several domains deserve attention.

First, the physician should assess clinical work honestly. Which activities remain enjoyable and sustainable? Which have become disproportionately exhausting? Are there responsibilities that should be reduced before others? A late-career plan can be revised, but the absence of any plan leaves change to crisis or fatigue.

Second, financial circumstances should be understood sufficiently well that decisions are not based on vague anxiety. The objective is not a universal financial target but confidence that likely needs, responsibilities and desired activities can be supported.

Third, the physician should examine identity outside medicine. A calendar containing only professional commitments is a warning sign if retirement is approaching. Interests and relationships require time to develop; they are difficult to manufacture after the final day of work.

Fourth, important relationships deserve renewed investment while there is still time to establish a different pattern of life. This includes family and friends but may also include selected professional relationships worth preserving after formal employment ends.

Fifth, health requires deliberate attention. Retirement plans dependent on travel, family activity or other ambitions are meaningful only if sufficient functional capacity is preserved to pursue them.

Sixth, knowledge transfer should begin before the farewell gathering. Potential successors and mentees need opportunities to assume responsibility while experienced support remains available.

Seventh, the practical architecture of retirement deserves attention: where to live, how to structure ordinary days, which professional registrations or memberships to retain, whether any clinical work will continue and what boundaries will apply to requests for informal advice.

Finally, the physician should think about what retirement is for. Stopping work is an event. Building a satisfying post-career life is a project. The objective is not to fill every hour but to create enough structure, connection, purpose and freedom for the next stage of life to become more than an absence of employment.

The final clinical encounter

At some point there will be a last patient. The physician may know that it is the last consultation or may recognise its significance only later. There will also be a final operation, final ward round, final delivery or final night on call. After decades in which these activities seemed permanent, their ending can feel strangely ordinary.

Perhaps that is appropriate. Medicine is ultimately a continuing enterprise. Patients still need care. Labour wards remain busy. Operating lists continue. New consultants make decisions. Trainees become specialists and eventually train others. The physician leaves, but the work continues.

Accepting this is not an admission of insignificance. It is recognition that contribution and indispensability are different things. No individual should be indispensable to a functioning healthcare system. The achievement lies in having contributed meaningfully while present and, where possible, leaving those who follow better prepared.

There can be dignity in an ending that is neither dramatic nor prolonged. The final encounter does not have to carry the weight of the entire career. It can simply be another episode of careful, compassionate practice, followed by the decision to entrust the next patient to someone else.

Conclusion

Retirement after a prolonged career in obstetrics and gynaecology is neither simply an administrative endpoint nor a prolonged holiday. It is a major developmental transition in which professional identity, personal relationships, health, finances and purpose are reorganised.

Preparation matters, but preparation should extend far beyond pensions and investments. The physician approaching retirement must also consider what parts of medicine should be retained, what can be relinquished, how knowledge will be transferred, which relationships require greater attention and what sources of meaning will remain when clinical responsibility ends.

A long career deserves an honest appraisal. There will have been achievement and disappointment, gratitude and criticism, successful decisions and outcomes that remained painful despite appropriate care. Fulfilment lies not in pretending that the career was flawless but in recognising the value of sustained service within the limits of human knowledge and human capacity.

For obstetricians and gynaecologists, the evidence of that service is unusually dispersed. It exists in women cared for through vulnerable periods of life, in children whose births were attended safely, in families supported through loss, in operations performed, in trainees taught and in services strengthened.

Retirement changes the form of contribution. It does not erase what came before. The final task of a medical career may therefore be neither another operation nor another clinical decision. It may be the ability to leave practice at an appropriate time, transfer responsibility

generously, carry forward what was valuable without remaining captive to professional identity, and enter the next stage of life with curiosity rather than apprehension.

A career can end without its influence ending. That may be one of the most enduring forms of professional fulfilment.

Ethics Approval and Consent to Participate

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Consent for Publication

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