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Forward

To write a book about retirement is a daunting and difficult task. While there is some commonality across the spectrum for those who retire or contemplate doing so, there is far more dissimilarity. Retirement is an individual process, and those who retire have many reasons for doing so. There are some individuals who never retire and die while still in the workforce. Among those who retire, many have mandatory retirements based on age, such as occurs in large corporations, academia, or the military and government service. There are some less fortunate individuals who have to retire because of health reasons. The remainder fall into the category of elective retirement.

Retirement means different things to different people. Some view retirement as the end of their life, while others view it as the beginning of a new life. The vast majority view retirement somewhere in between these two extremes. There is the need to prepare financially for retirement because of the attendant loss of wages. Yet there is much variation in how this is accomplished depending on whether a pension is established or if one must endow this for oneself. There is also some commonality in deciding where to live in retirement and what one's activities will be. There are a few other areas of general commonality, but the one standard is the vast dissimilarity among those who retire.

Within this large group of workers who retire, physicians are a unique group with unique challenges. The appropriate disposal of medical records so that they are secure but available to the patient later is an important issue. Other important issues include the timely notification of retirement so that there is no abandonment of patients and, of course, the acceptance of the need to retire as one's competency diminishes so that no patient harm is done. These are common to most physicians but can be dealt with in a variety of ways; there is no formula or checklist that one can follow that will ensure a smooth transition to retirement.

This book addresses the issues surrounding retirement of a subset of physicians-family physicians. Dr. Shahady has done a masterful job of pointing out the commonalities as well as the marked individualism of those who have retired. By the use of a large survey and selected references, he gives you a large platter of experiences that can be drawn from in planning your own retirement. He uses a number of anecdotes from the survey in a manner that allows the reader to begin to understand what other family physicians have gone through in preparing for retirement.

From my own experience of having retired 10 years ago and also in participating in the Pre-Retirement Seminars at the AAFP Annual Scientific Assemblies with Dr. Shahady, I find great validity in what Dr. Shahady offers in this book. I have found it is important to closely communicate with your spouse or significant other to plan your retirement together and set goals for your retirement. As a family physician, you probably will be overwhelmed with requests for your services. If you have set goals for yourself, it makes it easier to decide which requests you will accept and which you will politely decline. Good planning also can reduce the stress attendant with the life change of retirement. It is important to have a family physician to care for you and to follow a healthful lifestyle. As Dr. Shahady points out, this approach will give you a positive attitude toward retirement, and this phase of your life can be truly enjoyable. While this book can be helpful anytime during the retirement process, it is most helpful if read when you are first contemplating retirement. I wish you every success in your retirement.

Robert W Higgins, MD Rear Admiral, Medical Corps, US Navy (Retired)

Preface

In 1998, I decided to semi-retire. I had moved to southern Florida in 1994 after living in North Carolina for 19 years. My career as a teacher and practicing family physician had been very rich and rewarding. I enjoyed living in North Carolina, and I had many fulfilling and gratifying relationships with people all over the country and the world. My semi-retirement consisted of teaching at the University of Miami on a half-time basis. The rest of my time I spent fishing with my eldest son, friends, and residents from the program where I was teaching; traveling with my wife; and visiting our children.

After hearing about my retirement plans, Norman Kahn, MD, the vice president of Science and Education at the American Academy of Family Physicians (AAFP) and a longtime friend, asked me to consider conducting a seminar on preparing for retirement at the AAFP's Annual Scientific Assembly. I accepted the challenge, and it was the start of my interest in writing this book. Bob Higgins, MD, a retired family physician, partnered with me to conduct these seminars.

During these seminars, physicians shared their stories along with the challenges they encountered. Although their stories were individual, there were some commonalities among the physicians who were nearing retirement and those who were just beginning to think about retirement. Many of their stories had to do with relationships, emotional health, and productivity.

As I reviewed the available literature about retirement, I was surprised to learn how little had been written about physicians' retirements and that even less had been written about family physicians' retirements. The need for more research and more publications about physician retirement became obvious. So, with the aid of a medical student, I conducted surveys of 300 doctors from all specialties in South Florida. These doctors provided excellent ideas, anecdotes, and advice about retirement.

I knew this subject deserved more attention and that the support available from these kinds of conversations and the resulting data from surveys should be published. I suggested that the AAFP conduct its own survey. A more scientific randomized survey was designed and administered to 2,000 physician members older than age 50 years. An abbreviated version of the AAFP survey appears in *Appendix A*. In addition to the numerical data obtained from the surveys, a lot of excellent written comments were collected.

In order to enrich the survey data, six focus groups were conducted by phone. One group consisted of non-retired family physicians older than age 50 years, two groups consisted of retired male family physicians, one group consisted of retired female family physicians, and another group consisted of spouses of retired family physicians. Phyllis Naragon, who was then the Manager of Marketing Research for the AAFP (and now is the Director of Administration for the AAFP Foundation) led these groups with me. Phyllis has a talent for getting people to engage and share their experiences. Other family physicians granted Phyllis or myself individual interviews about their retirement experiences. The material in this book is very much a result of Phyllis's work and the willingness of many physicians and their spouses who shared so generously of their time and themselves. The survey results and the tales of the people we interviewed form the foundation of this book.

One clear picture that developed as a result of becoming immersed in the data and conversations was that, after

retirement, physicians need to find a way to develop another identity as their physician identity recedes from the fore of their lives. For many decades, these individuals have been accustomed to being thought of as "doctor" by their patients, their families, their colleagues, and their communities. They now face the question, "How do I not be known as Dr So and So?"

The female physicians in the focus groups thought that this was more of a challenge for men; most of these women already had spent a good deal of time devoted to being mothers and grandmothers. As retirement approached, they stepped with both feet into roles that, for years, they'd had one foot in firmly. Women had a sustainable identity apart from being physicians, whereas the men they knew did not necessarily have another identity from which they could get kudos and rewards as well as maintain their self-esteem. Men, of course, were also fathers and grandfathers, but they were less likely to feel as fulfilled by those roles as they did by being physicians.

We learned that relationships and interests that might have taken a secondary role during the years of practice were the saving grace for the well-being of many of these physicians. If these roles had been neglected or taken for granted, or if interests outside of medicine had not been nurtured, these individuals were not well prepared for retirement.

As I taught these workshops, I thought it was sad that so many of these individuals, who had led successful careers, might then become unhappy in retirement. Many of them did not know how to find themselves anew, did not have a plan for their later years—years in which they might be greatly fulfilled and content if they had thought ahead with some clear guidance. They had spent the first quarter of their lives preparing for a job; they had spent hardly any time thinking about what would come afterward. Retirement is a journey most of us will take, and the ship easily might sink without the lifeboats of relationships, interesting activities, and contributions to the world.

Using our experience, we can serve as peers guiding peers, just as we have in our medical lives. This one book will not solve the problems physicians face in their postretirement years; however, it is my hope and intention that this information will be valuable and useful for you so that your later years are filled with joy, peace of mind, and contentment.

Edward J. Shahady, MD, FAAFP

Introduction

Input the terms *retirement* or *aging* into any Internet search engine and links to sites on topics such as pathological aging (dementia), caring for aging parents, and how and where to invest one's money dominate the responses. Browse through any bookstore for books about retirement and you will find titles that reflect those same topics. Little is written about the other aspects of retirement. Publications and research specifically about physicians' aging and retirement are even more limited.

Nevertheless, financial planning is only one of the requirements for being prepared fully for retirement. This book provides information about the nonfinancial aspects of aging and retirement—that is, the *art* of retirement. Information was gathered from a variety of sources, including literature reviews, books, individual and group interviews of non-retired and retired physicians, spouses of retired physicians, and the author's experiences conducting seminars on retirement. A randomized survey of 2,000 members of the American Academy of Family Physicians (AAFP) older than age 50 years serves as the foundation of this book. Throughout the book, this survey will be referred to as "the recent AAFP survey." Each chapter contains quotes and anecdotes that reflect the rich and varied experiences of many retired physicians. Their comments feature the many lessons they have learned and the advice they wish to pass along to others.

I chose the word *art* as part of the title to emphasize the individuality of the retirement experience. Anecdotes and stories from those who have experienced retirement provide a richness that is not found in numbers and P values. Just as beauty is "in the eye of the beholder," happy retirement is dependent on the values, ideas, and desires of the individual. Retirement is what the retiree makes it.

In 1900, one in 25 people in the United States was older than age 65 years. By 1998, that number had increased to one in eight. People now live longer and retire earlier. It is not unusual to expect to live 20 to 30 years after retiring. Most of these years can be lived in good health, and life can be enjoyed to its fullest.

Technically, retirement signifies the crossing of a chronological line; it does not have to mean retiring from life. It is not the end of a lifetime's work but the beginning of a new chapter in life. Retirement can be even more rewarding and fulfilling than one's working years. This subjective assessment is entirely up to you and those who are closest to you.

The seven chapters in this book address the importance of blending the following key elements for a successful retirement:

- Making a successful transition from work to retirement
- Maintaining effective financial and legal resources
- Developing optimal health strategies
- Developing emotional maturity
- Seeking new relationships and nurturing existing ones
- Choosing enriching activities
- Creating quality living space
- Boosting your potential in all possible ways

The following is a brief summary of each chapter:

Chapter 1 is a discussion of the issues involved in planning for retirement. Economic and legal preparations can affect the retirement experience significantly, but emotional preparation contributes to one's feeling of purpose and, thus, the ability to sustain a positive attitude about the meaning of your life. This chapter includes suggestions from physicians and information from the literature about preparing for retirement, including the stages of retirement and considerations for partial versus full retirement.

Chapter 2 discusses the reasons for retiring. Several factors are involved in the decision to retire—some of which might be considered negative and some positive. This chapter gives you the opportunity to examine your own reasons for retiring as a prelude to planning.

Chapter 3 addresses the concerns and fears that physicians may have about retirement. Some of these include adequacy of funds, health, when to retire, spouse or partner's health and well-being, where to live, how to occupy one's time, leaving friends and family, how former patients will fare, and maintenance of self-esteem.

Chapter 4 discusses the relationship with one's spouse or significant other. Retirement can be a major challenge for significant relationships. This chapter includes suggestions from retirees and their spouses for helping a marriage not only survive but, in fact, thrive.

Chapter 5 addresses how to spend your time during retirement. A constant theme heard from retirees was the importance of cultivating a hobby before retiring and then allowing that hobby to come to life as retirement begins. Retirees also mentioned other options for staying active and productive after retirement. Female physicians comment on their assessment of the different needs of men and women in retirement.

Chapter 6 discusses closing your practice. The steps necessary to close one's practice include notifying your employees and discharging employer obligations; notifying your patients; retaining or disposing of medical records; notifying associations, organizations, and agencies; managing your accounts; coordinating with managed care and other insurance companies; and addressing many other details.

Chapter 7 presents the essential aspects of maintaining one's well-being in later life. Several factors are highlighted in this chapter, including social and emotional maturation, physical health, developing a positive attitude, recognizing and dealing with stress, the importance of friendships, and the keys to a rewarding retirement. Multiple anecdotes and research studies of the retirement years confirm that longevity and happiness are associated with a positive attitude.

If you read this book with an open mind, you will come to see that there are many positive aspects of aging. If you were creative in your earlier years, your creativity likely will **not diminish** with age. Your views about life and other people may be fuller and less stress-provoking. You can better understand what it takes to satisfy yourself, and you can be more confident. Your capacity to love, your curiosity, and your inclination toward altruism are all likely to increase, and your anxiety may decrease. Gratitude can deepen, and your sense of humor can be heightened.

There are many older physicians whose minds and spirits are not exhausted. Their retirement has not decreased their ability to use their gifts. The talent and intellect of so-called senior physicians is wasted when they are ignored or forgotten. Your only enemies are any negative assumptions you may have about aging and potentially succumbing to obsolete stereotypes about being retired and, eventually, elderly.

By seeking to subordinate the negatives of aging to the many positives, it is my hope that this book will guide you toward a successful retirement. It is my intention to help you find a way to share your many gifts. **As a retired physician, you can be one of our nation's greatest treasures. Take responsibility for not allowing your gifts to be a hidden treasure.**

Acknowledgements

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Chapter 1: Preparation and Planning for Retirement

“Professionals seldom recognize that planning for the later stage of one’s life is equal to the planning and training that goes into the inception of your career. Too often matters are left more or less to fate and treated with a form of denial. Professional or not, you will age and you will come to the end of your working life, and you will have to deal with the consequences of inactivity and ultimately failing health. Facing the realities early on and planning for their eventuation is the sensible thing to do.”(1)

George Anast, MD

Individuals who are contemplating retirement are likely to consider the following:

- Is retirement a reward for many years of hard work?
- Does it offer time to enjoy life with less responsibility?
- Have I given myself permission to enjoy it?
- Finances are important to successful retirement, but is it the psychological and emotional components of retirement that determine retirement “success”?

Retirement preparation is 92% economic, 82% legal, and 72% emotional (2). Economic and legal preparation greatly impacts the retirement experience, but emotional preparation significantly affects one’s sense of purpose in life and the development of a favorable attitude toward retirement.

How well are you prepared to manage the transition into retirement? What are your strategies for a rewarding life? How will you spend your time? These and many other questions need to be considered in order to plan thoroughly and thoughtfully for your retirement.

A number of retired physicians offered the following advice when they were questioned about preparing for retirement:

“Start preparing while you are still in active practice. Take time for self, institute hobbies. Keep in touch with your family and friends. When you are off work, turn your work button off. Have a place to get away (do not take work with you). Be sure you have competent, friendly physicians to substitute for you when you are away. Return favors to them bountifully.”

“Be prepared for the changes that will be! Consider the effects that will take place on lifestyle and activity and come to understand these effects. Educate yourself about retirement — the pitfalls and the positives. Understand probable changes of people and family addressing and treating you as a retiree.”

“Develop interests before retirement. Plan to learn a new hobby or activity you may have wanted to do but had no time to do.”

“Always find something that will keep you challenged mentally and physically.”

“Before retirement, have plans set up to help spend time usefully and constructively and in ways that are interesting. With forced retirement such as mine, you feel as if something extremely important was abruptly taken from you, leaving you [feeling] useless. This can lead to terrible depression if alternatives are not found to fill your days.”

“Don't wait until you retire to take care of yourself. Take time for yourself while you are still practicing. Find something you enjoy doing besides your work.”

“If you are a physician contemplating retirement, I would recommend that you, first of all, thoroughly evaluate reasons for your present dissatisfaction with your professional work. Are the conditions [that are] causing you distress out of your control to change? Secondly, consider how the implications of your reduced earnings will affect you personally as well as your family and your future community responsibilities.”

“Do what's right for you. Some may be happiest continuing in full-time practice; others (like me) see broader horizons. Plan to include a stepped up exercise program including strength and endurance training—it'll make you younger!”

“There is a real life after retirement. Don't fear it.”

Some physicians provided these unfortunate responses on planning and preparation.

“When no joy is derived, no pleasure found in medicine, and especially when you find yourself hating to go to work – it's time to get the hell out. That's what happened to me.”

“Take business courses, quit wasting your time trying to make a living in medicine. Engineers, teachers and even garbage men in New York City earn a better wage than we do. Stop carrying the country on your back – [these courses are] free!”

Hopefully this book will help reduce the number of physicians who wait until they may be unhappy and unproductive before thinking about retirement. Planning and preparing are the keys. Consider that parents plan the first third of our lives. Most of us plan and

re-plan, countless times, the second third of our lives. We put thought into our education, our marriage, raising children, a place to practice, and so on. It is now time to plan for the last third of your life. Retirement may last 30 or more years. Other than financial planning, most physicians spend little time thinking about their retirement years. In fact, some believe they can go on practicing forever.

The Renewal Stage of Life

In *Winning Ways to Retirement: Your Personal Discovery System* (3), Marge Powers describes retirement as the beginning of a different lifestyle rather than an ending. Therefore, it requires the same process of self-analysis that you might use when you go through a job or career change. She states, “This is the renewal stage of your life. You are free from the stress of climbing the ladder and able to pursue the ideas and activities that really matter to you. There are now many options open to the enlightened person who is transitioning from the world of work.”

What will life look like when you no longer have the structure and accountability of a job? How would a typical day unfold? What activities will you be doing, and how and with whom will you be doing them?

Careful introspection and planning are important for the transition—thoughtfully considering what you need and want to do, how you are going to do it, and when you are doing to do it. While flexibility is important, the more specific the plan is, the easier it will be to fulfill. Powers believes that individuals need to approach retirement by generating options similar to they way they approached any other life event in the past. Option generation gives you an opportunity to explore the richness and possibilities of this phase of your life. Through the aid of a questionnaire you can educate yourself about where you want to be tomorrow, what makes you happy, how to best identify your short- and long-term goals, and how to develop a plan to achieve those goals.

Goals will be an essential structure for your plan. Powers cites the following reasons (3):

1. Success comes from having goals.
2. People who live long lives are often found to have a life purpose.
3. Happiness requires goals.
4. Goals give you energy (motivation).
5. Goals make you unique.
6. Goal setting is fun.
7. Goals give your life meaning.

Goal setting may seem obvious or unneeded to some, but think about how you approached life in the past. When you were younger and motivated, did you have dreams you wished to bring to fruition and goals you were trying to attain? As you entered middle age were you more content because your goals were met, and in the past few years have you felt less motivated? Perhaps goal setting may help you become re-

motivated. Try it! In fact, trying new things will be an important aspect of your later years and motivation will be crucial to feeling fulfilled. Now is the time to visualize a life where you are devoting yourself to the ideas and activities that matter to you. Your commitments will lead you in fulfilling yourself and your life if you consider carefully what those commitments are. If you do not stop to consider what has meaning for you and where you want to put your time, you may find that your days may wither in both number and value.

To design your own best plan, you first need to know your true desires and then begin to choose activities in accordance with those desires. Coordinating all the activities you may wish to take on, such as volunteering, new social activity, travel, and perhaps part-time work, can be a challenge—especially if your daily and weekly routine has been relatively fixed the prior 25 years. Without a plan, the transition will be far more difficult and far less effective.

Some retirement changes, such as extended traveling or volunteerism, might require months to years of pre-planning. One physician I interviewed said that he'd left for Vietnam within a week of retiring. In addition to leaving his medical practice, he and his wife had decided to divorce after 44-years. Facing these losses, he joined a project at his own expense for 2½ months. He originally volunteered with young doctors in a clinic and an orphanage but has since returned several more times. In addition to Vietnam, he has visited Tanzania, other sites in Africa, Newfoundland, St. Lucia Island, Jamaica, and Mexico. He devotes a couple months each year when his health can accommodate the trips. "In those third worlds," he says, "the doctors are too few, they only do the special things, and their assistants do all the primary care and they're usually a good target [for education]." Although the patients do not speak any English, and the interpretation "leaves a lot to be desired," he found his fulfillment in teaching healthcare providers. He now has a whole set of programs he has developed to use for Rotary Clubs and other medical volunteerism programs that compare the healthcare delivery in four different foreign sites.

This physician goes on to describe a fellow physician who retired before him and has a contrasting lifestyle, one that developed as a natural segue from his existent lifestyle. "He's busier now than I am," his former partner says. "[He's] shooting his age in golf, and he's a carpenter. He always has been one. He loves to do cabinetwork. He does woodwork for his kids' house now."

It is clear that maintaining productivity of some sort is crucial for most retirees. One physician, looking ahead to a future retirement, commented on what he considers to be another necessary adjunct to maintaining productivity: "I feel like there are definite life cycles in terms of being productive and although I want to stay productive, [I'm looking forward to] having more opportunity to be more introspective . . . I think that's sort of the reward of growing older and wiser, hopefully."

Taking the Leap

The decision to finally take the leap to official retirement has two major components. The first is financial. This is a more objective criterion and can be easily measured. However, the second component, psychological or emotional preparation, is a subjective criterion and there is no standard against which to compare your progress. “The changes required in mental attitude and outlook are profound, and often unsuspected,” George Anast writes. (1)

Before you announce your retirement, make sure you have a plan in mind. Do not be casual in your decision to go public with the retirement decision. Once you announce your retirement or strongly consider it, things will change. Your life has influenced the lives of many others—your family, staff, partners, patients, etc. Your retirement will now have a major impact on their lives. As you progress through your planning, you need to consider the significant needs of all those who have been part of your life. Your family, and especially your spouse or significant other, is your first responsibility; Chapter 4 discusses this issue in more detail. Chapter 6, on closing your practice, discusses patient and staff issues. Preparation will help you and others address the issues that are created by your impending retirement. Developing a list of questions and potential answers before announcing your intention goes a long way toward decreasing the anxiety that may be created by your leaving your practice. Most retirees recommend at least a year to prepare your office and patients for your retirement. To work out the details, it may take longer for you, your staff, your patients, and your spouse and family.

Like any other life event, preparation is essential. The preparation need not be complex. The elegant simplicity of preparation was well stated by a retired physician who advised: “Approach retirement from a position of strength. Have at least one hobby, at least one friend that you share with, and have a common interest with your family.”

Full-Time Versus Part-Time Retirement and the Stages of Retirement

Withdrawing from practice gradually seems to be the method of choice for many physicians. The recent survey of retired AAFP members over age 50 revealed that 66% were fully retired and 34% were partially retired. Of those who were not retired, 40% were considering full retirement and 60% thought they would probably choose partial retirement. In a breakdown by age group of the group of retired respondents, it was shown that as age increased, the choice of full retirement increased. For those who had not yet retired, however, no matter what their age, the majority still favored partial retirement.

Why is it that those who are not retired are more interested in partial retirement than those physicians who have already retired? Possible answers to this question include:

1. They felt comfortable practicing medicine and did not feel they had to retire.

2. They were able to tolerate the hassles of medicine and did not feel the need to retire.
3. They were not financially able to retire.
4. They did not know what to do with themselves once they retired; medicine was the major activity in their lives.
5. Their identity, that is, what they thought of themselves, was tied to medicine.

Retirement is not a single defining event; rather it is a process. Whether physicians decide to choose partial versus full retirement may indicate what stage of that process they are going through. Two authors, Atchley (1975) and Weisman (1996) have described these process stages. Although their views and terms differ, they share a helpful message. First of all, it is crucial to recognize that there *are* stages (or phases). Also, within these stages, however they might be labeled or defined, there are normal and not-so-normal steps. Each physician goes through the stages at his/her own individual pace, and some stages may be skipped or never reached.

Atchley (4) describes six stages/phases to retirement.

1. ***Remote Phase.*** This phase is present early in a career. Aside from financial considerations, one is not doing much to prepare for retirement.
2. ***Near Phase.*** A target date is set for retirement. You now begin to fantasize about what you will do after you retire. Some people may actually have developed a plan but most have not.
3. ***Honeymoon Phase.*** This consists of the first few months of retirement. You now begin to act out your fantasies, both good and bad.
4. ***Disenchantment Phase.*** When this phase/stage arrives, boredom sets in and the retiree misses her/his work role. Daily golf, reading, traveling, etc., does not feel sufficiently fulfilling. The retiree does not feel as if she/he is contributing to society.
5. ***Reorientation Phase.*** When this stage begins, the retiree finds new roles that provide satisfaction and feelings of self-worth.
6. ***Stability Phase.*** A satisfying routine is established. Some reach this point faster than others. Some never reach this point.

Weisman (5) divides retirement into four stages.

1. ***Incipient Retirement*** is the stage before actually retiring. The physician is thinking about the possibilities for the future. The prospective retiree feels caught between feeling increasingly bored and fatigued, and feeling indispensable. This stage is characterized by thoughts and statements such as: "What will happen to me if I retire?" or "My spouse has been after me to work less, travel more, and do something else besides complain," or "I hate to hear the phone these days. I'm getting stale," or "Nothing is like it used to be." The physician may be busier

than ever doing less and less of substance. This is the so-called “camouflaged retirement.”

2. ***Semi-Retirement*** usually reflects physician indecision. It is common to cut down on work hours and take on other responsibilities. Weisman writes that he thinks this phase is “phony.” Even for those claiming to be practicing part time, the principle objective is to find out how retirement feels or to hang on while work slips away. This stage can help with the withdrawal symptoms that come with removing oneself from practicing medicine. It also can give the physician an opportunity to try out some new options for maintaining a sense of self-esteem and self-worth.
3. ***Official Retirement*** is when the retiree and those around him officially recognize the retirement. Some type of ceremony is generally performed and the individual is acknowledged. It is honorific and helps the retiree maintain a sense of prestige. After the ceremony the retiree is well advised to have the following 6 months well planned. This is a sort of honeymoon phase to become accustomed to a new role and a changing life.
4. ***Terminal Retirement*** is the later stage of life. Society expects good behavior and self-support. The physician who feels sorry for himself or herself encounters this stage sooner than expected. With chronic inactivity, deadening routine, and no pastime providing significance or meaning, the physician can become depressed and eventually develop ill health and die. Death is inevitable, of course, but most people want to engage with life as much as possible for as long as possible. Being active with your body and mind puts this terminal phase in its proper place.

Retired or nearly retired physicians offer these further insights into planning full versus partial retirement.

“Partial retirement works great – whereas I’ve heard several other physicians who are fully retired express some regret. I have found more than enough opportunities to continue to serve in our community, and made time for CMEs, and did better on my boards this year than ever before. Plus, my income from part-time work is much appreciated.”

“I know I just can’t give up the idea of keeping up with some of the things that are changing in medicine; they’re just too fascinating.”

“I tried working part time to see if I could get by a little longer without retiring but I ended up doing four and a half days work in three days and the paperwork piled up. If you’ve already got a full time plus practice it’s difficult to go part time.”

“My plan was to work much longer than I probably will. I have some health problems that have made me reduce my schedule. I found out quickly that

fixed costs increase to the point where it costs you more to stay in practice. I think that's what's referred to as taking income to supplement your practice. I'm still beyond my fixed costs but I'm not really earning anything for my other partners. If I slow down more I actually will be in a position where the fixed costs may exceed what I earn."

One of the interviewed retirees asked, "Is the beauty of retirement [connected with] getting away from medicine?" A second responded, "Some physicians are comfortable with [getting out of medicine] and some are not. I don't think we want to put a value judgment on what's the best way to do it."

Those approaching retirement age should probably consider both part- and full-time options. One fully retired physician stated, "I think some, like myself, have chosen to pretty much divorce from medicine. I have found that there are aspects of life other than medicine. A graceful exit, and redirecting energies in non-medical pathways and pursuing long-delayed or deferred hobbies, has its advantages."

The above comments reinforce the notion that multiple options exist for retirement planning. Although these comments appear to reinforce that retirement is a staged or phased process, the stages may not be quite as precise as Atchley and Weisman believe. However, evolution of an individual's retirement is exactly that "individual."

Changing Locations after Retirement

One of the other big issues in planning is deciding whether to move or stay put. Moving has both positive and negative components. Friends, neighbors, familiarity with your surroundings and owning a house that has little-to-no mortgage are the positives of staying where you are. Moving means meeting new people, a new environment, and a new mortgage. On the other hand, moving provides an opportunity to become a new person without the old responsibilities. It may be worthwhile to try a 6-month temporary move to see whether you like it. Many retirees find themselves moving within the same geographical area. It may be wise to downsize, or to decrease one's housekeeping load and upkeep on property.

Some retirees like to split their time between two settings. Retirees who live in more northern, harsher climates in the winter are probably the ones that more frequently choose this option. This option provides an opportunity to develop new relationships and hold on to the old ones. Some retirees find themselves spending more time in the warm climates until their health declines. Once in ill health, closeness to family and a more familiar environment influences the decision to return home.

Emotional Preparation for Retirement and the Effects of Aging

As stated in the beginning of this chapter, while planning for retirement involves economic and legal components, it is emotional preparation that provides for continuing refreshment of one's purpose in life and enhancement of a more favorable attitude toward retirement.

The following is a list of issues provided by Liss et al (6) that need to be recognized or addressed in order to emotionally prepare for retirement.

1. *Retirement is a major life change.* Most physicians have not made such a major change in many years. You need to gather the emotional resources for the changes that come with retirement.
2. *Your health and your spouse's health will change.*
3. *Prevention for your own health becomes a bigger part of your life.* Tests, immunizations, exercise, and nutrition must all be focused upon with a keener eye.
4. *A fixed income may not tolerate the unexpected.* You will need to keep in mind that you will have other unexpected expenses, such as your children having expenses where they will need and appreciate your help.
5. *Preparing for ill health and the end of your life.*
6. *Finding a social support system* other than your practicing colleagues.
7. *Finding an activity or project* that feels meaningful to you.
8. *Learning to identify yourself* as something other than a practicing physician.
9. *Getting ready for your spouse to play a more important role in your life.*
10. *Inventing a different view of retirement than it being a diminished status at the end of life.* "Retirement is the dessert of a gourmet meal," Liss writes.

Discussing retirement with others who have retired helps incorporate new views and feelings. Call the local medical society or the state chapter of the AAFP and obtain some names of physicians who have recently retired. You may know a non-physician who you respect and who has recently retired. Develop a *mentoring relationship* with some of those retirees. When you have a question, give them a call. They are usually eager to give you ideas, share their mistakes and experiences, and suggest solutions that worked for them. They may also be willing just to listen. Your spouse may find it helpful to talk to spouses of retired physicians.

Expect retirement to bring changes. In the initial point of retirement, we have reasonable health and energy, and ample money. With the passage of time, we need to prepare ourselves mentally for the requirements of aging. The demands and needs of our children and grandchildren, and the death or disability of someone close will have its impact.

We cannot change the process of aging. Despite all its challenges, it is a natural process. We will encounter conditions that diminish our physical abilities. We may need to obtain

large-lettered telephones, extra-loud alarm clocks, talking watches, and magnifiers for what may become our impaired hearing and sight. As our short-term memories decrease, we will develop habits of writing down important things. We will encounter difficulties, and the wise among us will learn to ask for help in order to retain our dignity and our initiative and personality to the best of our abilities. The challenges of growing old are to do it as gracefully and as comfortably as possible. We cannot completely know what lies ahead. We can, however, begin to develop in our earlier lives a philosophy to face the uncertainty with a positive resolve—to accept what is not changeable and focus our energy on what can be changed.

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Chapter 2: Reasons for Retirement

“I enjoyed family practice all my practice years — the frustration of government and HMOs, etc. were not enough to make me want to quit. My reason for retirement was to be sure my patients received excellent care. During my years in practice I saw too many physicians who refused to retire even though they were years behind the times. Early in my career I decided to retire while my brain was still functioning. I have also enjoyed retirement”.

Retired Family Physician

There are several factors involved in the decision of whether to retire. Age alone is not the primary reason that retirees mention. Some other reasons that spur the decision and that can be viewed as negative reasons are decreased health status, outdated skills, and decreased capacity to deal with change. Age combined with another factor—such as feeling that your knowledge and skills are outdated or that you lack the energy to update your knowledge and skills—appears to be a stronger motivator. As we mature it is more difficult to absorb new knowledge and skills and this self-education may require more energy and time. An even stronger motivator for retirement relates to what it takes to continue dealing with the “hassles” of medicine. The administrative aspects of caring for patients have increased dramatically in the last decade and it is more difficult for the older physician to acclimatize to these demands. Multiple studies (1-8) point out the “hassle factor” as one of the major reasons physicians are leaving practice. As one retiree stated “I retired because I felt crowded out. I was making less [money]. Recruiting young partners, pacifying them, and trying to help them make money was not fun. I really resented having to retire.”

Although some physicians cite hassle factors as a major reason for becoming dissatisfied with medicine, this is not true of the majority. A study of career dissatisfaction among family physicians and general practitioners (FP/GP) in 1996–1997 found more than 17% were dissatisfied (9). Among personal factors given, age was the most significant one associated with dissatisfaction; 25.1% of those aged 55 to 64 years reported dissatisfaction compared with only 10.1% of those younger than age 35. Other personal or professional characteristics that were significantly associated with FP/GP dissatisfaction included osteopathic training, graduation from a foreign medical school, full practice ownership, and an income of less than \$100,000. The physicians who reported they were dissatisfied with their careers were much more likely to report difficulties in caring for patients. This group felt strongly that they had insufficient: clinical freedom, time with patients, continuity in their patient relationships, ability to provide quality care, and communication with specialists. They also felt there were excessive financial penalties for their clinical decisions.

Stated in positive terms, 83 % of the FP/GPs were very or somewhat satisfied with their careers. Perhaps this helps us predict how many physicians will go into retirement with a positive versus a negative attitude. Hassle factors are common to all physicians but the

degree to which these perceived annoyances impact attitude and level of satisfaction varies.

There are also a great number of positive reasons for retiring. Foremost may be the additional time — to enjoy hobbies you have been putting on the back burner, get to know your spouse and family better after years of hard work, travel, and enjoy life's more simple pleasures.

No matter what your reasons are for considering retirement, give some thought to what seems to be your own leading reason. This major reason is your motivator and it will have a fundamental affect on how you live your life after you alter or leave your career. If your primary motivator is to escape hassles, you may discover that you indeed become free from that stress after retiring. However, you then may be faced with the stress of uncertainty about what you need to do to satisfy other needs.

A 2001 survey of physicians in all specialties, conducted by Lees et al (10), concerned the emotional impact of retirement. The data compared responses of retired physicians under age 65 with those over age 65. These Texas physicians gave the following leading reasons for retiring: It was time to retire; work was no longer necessary to achieve economic security; they needed more time to enjoy things; and they experienced a loss of autonomy and control. One third of respondents assigned this last reason as their foremost justification for retiring. Loss of autonomy was given as a greater factor for retirement than their reduced income under a managed care system or a fear of malpractice claims being made against them. This survey also identified that physicians *who retired less than a year previously* had a less favorable attitude toward retirement. Physicians *under age 65* also had a less favorable attitude as well as a greater sense of regret and inertia. On the other hand, the latter younger-aged group felt a greater sense of freedom and happiness and was more optimistic. The conclusions from these data, which reflect responses from a nonrandomized group of physicians from different specialties, provide somewhat of a different viewpoint than that stated in Chapter 1 from the AAFP study, which was a randomized study of one specialty group. These types of studies are few and, to my knowledge, the latter study is the best to date of the attitudes and opinions of family physicians. Depression and stress was present in 27% of the Texas physicians. *Depression* was associated with a change in health status, retiring because of diminished skills, and forced retirement. The survey found that when these physicians felt stress in their practice they experienced a higher frequency of anger, regret, change in health, and feeling of purposelessness in their lives.

In the recent AAFP survey, one third of respondents listed frustrations or hassle factors as one of their top three reasons for retiring or considering retirement, but an equal number listed positive reasons such as pursuit of other interests, time to travel, and time with family (Table 1). There were a few differences among females as compared to males.

Forty percent of the women respondents listed “spending time with family” among their reasons as compared to 27% for men. (This approached statistical significance with a p value of .06). Government impact on medicine was selected as a reason by 40% of the

male respondents compared to 24% of the females. This was statistically significant at $p=0.01$ (see Table 2). Age also influenced the responses. More positive factors for retiring were cited more often by the younger (age 50-59) group (see Table 3).

Table 1.—Results of the AAFP Survey of Top Three Reasons for Retiring or Considering Retirement.

38.0%	Want to pursue other interests
37.9%	Government impact on medicine
35.1%	Time to travel
34.5%	Managed care frustrations
28.4%	Spend more time with my family
22.5%	Burned out
21.9%	Practice management issues
17.2%	My health
17.1%	Other reasons
9.3%	Time to read

Of the 2000 randomized members of AAFP over the age of 50 to whom the questionnaire was sent, 831 responded; 89.7% were males and 10.3% were females. Ages ranged from 50s to over 80. Some of the more representative comments that fall into some general categories (similar to breakouts given above) are provided here.

Age, burned out, time to retire. Respondents who reported these reasons showed varying perspectives. One said that after 30 years, it was “not one big thing but many little ones.” Many mentioned being tired, and some mentioned feeling decreased ability to practice medicine, including an inability to keep up when they were partially retired. A number of respondents mentioned their fear or rising inability to cope with some aspects of medicine as it has evolved. One mentioned being frustrated with academic medicine. Another mentioned what he felt was a “negative impact of hospitalists, hospital employment with all new physicians in [the] area.” Another wrote of feeling that “I was not staying sufficiently informed to practice safely.” Many physicians expressed comments in this same vein, such as “Believed that I was getting too old to deal with the recent advances and the new medications,” and “Couldn’t keep up with more rapid changes. Most doctors are now more interested in diseases and conditions than in the patient.” Another respondent echoed that perspective: “I retired for a couple of reasons. I don’t think the quality of medicine that we’re practicing today was up to my standard. The other reason I left was because I couldn’t get [physicians to cover for me]. I was a solo physician and most of the younger physicians wanted to take care of healthy young people, not older, sicker people.”

Many answers reflected a view that, as one respondent put it, “my time in medicine was over.” One respondent reported feeling a sense of “losing it,” and a third physician said “I asked a friend who had just retired, ‘How do you know when’s the time?’” And he said, “You’ll know,” and he was correct.” One respondent wrote, “Well, I reached the age of 70 and I didn’t want to stay in. I had a great uncle that I watched practicing medicine when he was up into his eighties and he did things very poorly. I didn’t want to practice to the point of losing my competence.” One of the interviewees for this book told how he and other partners were placed in a position of protecting the senior partner, a superb, well-loved, and highly competent physician, now in his mid-60’s and not keeping up. “In the hospital situation, we actually took him off the hospital calls so he wasn’t seeing hospitalized patients. . . . there was a period that it was uncomfortable, and also there was a financial issue that when he became less productive, we were working to support him, so I’ve seen that part of the spectrum and I don’t want to be that. I have fear of that happening to me.”

Reasons pertaining to spouse, family. Several male respondents reported issues pertaining to their wives: One’s wife was “recently ordained, I’ll go with her but plan to work a 0.6 equivalent.” Another’s wife had “had a stroke, and to keep her at home, I had to become the main caregiver, which is full time.” Another’s wife was “tired of being alone.” Another said, “I try to balance work, family and church now.” One physician wrote: ““My retirement was at a young age, partly because of changes in medicine over the 23 years I practiced. But also I felt it was more difficult for me to keep up and I was at the point with three teenagers at home, I felt I could be a better mother than a physician. There were plenty of women physicians in our town to handle medical care and there’s only one me to handle three teenagers. My group got bigger and bigger it seemed that the quality of medical care and the compassion got less and less. So the reward wasn’t quite as great for me to stay in medicine.”

Malpractice, insurance, government intrusion, managed care, associated money concerns. Respondents listed reasons reflective of the malpractice crisis, with catch phrases such as “Lawyers,” “Litigious society,” “Malpractice threats,” “Not able to get liability insurance,” “I didn’t take HMOs,” and “Fear of lawsuits.” One wrote, “I was so angry at the intrusion of government, insurance and paperwork. It required a double coronary artery bypass. Anger is hard on one’s health and happiness.” One cited, “Decreased reimbursements and increased overhead.” Many cited the oppressive nature of paperwork. “I guess one of the things that I’d have to say is that I got out of medicine, because medicine had become something that I hadn’t trained for and a paperwork nightmare. I was no longer being fulfilled by it, I was just being pulled in six different directions, I was never where I was supposed to be, someone was always angry, no matter what I did and it became so frustrating that it was no longer fulfilling.” Another physician wrote, “I retired quite late because I had to get someone to take over the practice and I simply realized that I really couldn’t do it much longer. I was 68 then and it was becoming a pain. I did OB and it was becoming exceedingly onerous. I did have someone who moved in and she obviously wasn’t able to cope with it alone like I had

been doing so I had to hang on until she got someone else to come in. The amount of paperwork and time spent on that was becoming excessive, as well as the work. I just had to stop.” One wrote simply, “Paperwork, paperwork, paperwork, paperwork.”

Health issues. Respondents mentioned the occurrence of such events as a fractured hip, severe peripheral neuropathy; myocardial infarction; poor memory; and “a CVA. All symptoms improved, but [I] retired.” One wrote, “Depression — wife left, divorce.” Another said, “I thought I was burned out, but 6 years later I found out I had a parathyroid tumor which had been causing my symptoms for several years. I am now ready to return to practice at age 71½.” One physician said that “Health was really the only reason.” And another said, “I want to retire before my arthritis prevents me from doing what I want to do.”

Freedom, interests, time, fun. Respondents mentioned they wanted the freedom and time to “Live life!” as one physician put it. These individuals wanted to have the time to be able to write; “develop new challenges and pursue other interests”; pursue being a “full time artist”; “better enjoy life; do what [I’ve] always wanted”; and go “back to college.” One simply wanted “more fun,” and another said, “When I entered medicine everyone said medicine was fun and it was great fun initially and the fun has gone out of it. Another cited “having free time to decide and do whatever I want to do.” Another echoed that sentiment saying, “No schedule, time my own.” Another started a book business. One respondent was thrilled “Not being on call! Not dictating nightly.” Another wrote, “By that time in life (70) I can’t see myself spending enough time to keep up — would rather have the freedom to live outside of medicine.” A physician wrote, “I had always wanted to retire early. I had a strong second interest in life for playing music. I really wanted to spend a significant amount of my time doing that and being in practice, I wasn’t able to. . . . So I had a long-term plan that I would retire but then some health issues of my own and my spouse’s provided a springboard for making the decision to retire.”

Making a difference, community service, teaching, public health work. A number of respondents wanted to pursue activities that would have them feel fulfilled as contributors to society. Several wanted to do (or return to doing) medical missionary work or volunteerism, including volunteering at overseas medical clinics. One respondent wrote that he wanted to do more public health work as opposed to office practice. Several mentioned commitments to teach. One wrote “I am doing entertainment, edutainment (I’m a singer/guitarist – I customize parody songs for medical organizations, pharmaceutical products, etc.), and health/wellness presentations now.”

Freedom from patient responsibility. Some respondents referred to feeling a need to get away from the responsibility for patients, and a few wrote of a desire to escape from patients themselves. One gave as a top reason, “Pressure from addicts to pain medication. Best way to avoid these people was to retire completely, and [the] time had come anyway (age 84).” One even wrote, “I was burned out, overextended and I did not like myself. I wore dark glasses to disguise myself in public so patients would not bother me.”

Practice management issues. Some respondents mentioned examples of having to leave work, such as one who cited an “inability to continue meaningful employment (forced out),” or one who reported an inability to work out a reduced call schedule with associates. One reported that the “company folded, offered good incentives.” Others mentioned being offered retirement incentives including early retirement offer “with perks.” One wrote of taking “in one new family physician every year for 5 years, and then there wasn’t any room for me.” A physician wrote, ““I may have the most simple and straightforward reason—my company folded. My job evaporated suddenly on 60 days notice in front of me and that’s why I elected at that particular moment to cease and desist.”

Physicians’ reasons for retirement do predominate on the negative side of the list. But there are enough positive and encouraging comments to form a basis for realizing that the negativity may be what is needed to motivate your retirement. But your retirement will not be successfully sustained without a greater emphasis on the positive reasons, or at least the positive destination. Successful retirement is better defined by what you are going toward rather than what you are leaving. Spending more time with family, traveling, reading, and pursuing other interests are the top positive reasons listed by retirees. Chapter 5, which discusses how to spend your time in retirement, provides some excellent suggestions to consider when identifying and discovering the pursuits that will bring you pleasure.

Table 2.—Reasons for retiring by gender

	Female	Male
Burned out	21 (24.7%)	165 (22.2%)
Spend more time with my family	34 (40.0%)	201 (27.1%)
Government impact on medicine	20 (23.5%)	293 (39.5%)
Time to read	12 (14.1%)	65 (8.8%)
Want to pursue other interests	34 (40.0%)	280 (37.7%)
My health	16 (18.8%)	126 (17.0%)
Managed care frustrations	22 (25.9%)	263 (35.4%)

Practice management issues	14 (16.5%)	166 (22.4%)
Time to travel	33 (38.8%)	257 (34.6%)
TOTAL	206	1816

Table 3.—Reasons for retiring by age group

	50-59	60-69	70-79	80+	Statistical Significance
Burned out	109 (30.1%)	40 (26.5%)	28 (12.0%)	9 (11.0%)	p=<.001
Spend more time with my family	124 (34.3%)	44 (29.1%)	49 (21.0%)	18 (22.0%)	p=.003
Government impact on medicine	97 (26.8%)	47 (31.1%)	124 (53.2%)	45 (54.9%)	p=<.001
Time to read	41 (11.3%)	8 (5.3%)	20 (8.6%)	8 (9.8%)	
Want to pursue other interests	179 (49.4%)	55 (36.4%)	62 (26.6%)	19 (23.2%)	p=<.001
My health	42 (11.6%)	28 (18.5%)	43 (18.5%)	29 (35.4%)	p=<.001
Managed care frustrations	103 (28.5%)	51 (33.8%)	100 (42.9%)	31 (37.8%)	p=.003
Practice management issues	75 (20.7%)	27 (17.9%)	59 (25.3%)	19 (23.2%)	
Time to travel	151 (41.7%)	55 (36.4%)	63 (27.0%)	22 (26.8%)	p=.001
TOTALS	921	355	548	200	

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Chapter 3: Fears and Concerns about Retirement

Physicians may experience significant fears and concerns as they consider retirement. Questions are bound to arise: Will I have enough money? Who will take care of my patients? Will I keep my health? Will it be boring? Is this the beginning of the end of my life? After treating patients for all those years, what else is there? **If I am what I do . . . if I do *nothing*, what am I?**

When physicians face these questions about life after retirement, they may inadvertently delay or alter their desire or need to retire. A 1996 Medical Economics survey of 7,500 physicians found that their biggest worries about retirement revolved around the adequacy of funds (67%), their own health (44%), when to retire (42%), spouses' health (28%), where to live (26%), how to occupy their time (25%), how former patients would fare (12%), and leaving friends and family (11%).

The recent randomized survey by the American Academy of Family Physicians (AAFP) of 2,000 members over age 50 (831 responded) also found that the potential inadequacy of funds is physicians' primary concern regarding retirement (Table 1). When the responses to this question were broken down by gender, the only significant difference was the concern about the changing relationship with one's spouse. This was a primary concern for 10.9% of the male respondents and only 4.7% of the female respondents.

Table 1.—AAFP Survey. Responses to the question: “What are your major concerns about retirement? (Please check three that are most important.)”

54.9%	Won't have enough money
30.0%	Will become bored
30.0%	My health
29.2%	Keeping up with medicine
23.7%	No longer making a contribution to society
22.7%	My patients don't want me to retire
15.3%	Future care of my patients
12.4%	Will not know how to spend my time
10.2%	Relationship with my spouse
5.3%	Don't have other interests
13.8%	Other

There were significant differences in the survey across the age groups (Table 2). Concerns about patient care issues, keeping up with medicine, no longer making a contribution to society, fear of becoming bored, and individual health concerns were higher in the older ages. The younger physicians (50 to 59 age group) were more concerned about financial issues.

Table 2.—AAFP Survey. Breakdown by age to: “What are your major concerns about retirement? (Please check three that are most important.)”

	50-59	60-69	70-79	80+	Significance
Won't have enough money	260 (71.8%)	73 (48.3%)	94 (40.3%)	28 (34.1%)	p=<.001
Will become bored	99 (27.3%)	59 (39.1%)	76 (32.6%)	14 (17.1%)	p=.002
My health	101 (27.9%)	39 (25.8%)	72 (30.9%)	37 (45.1%)	p=.012
My patients don't want me to retire	55 (15.2%)	44 (29.1%)	64 (27.5%)	24 (29.3%)	p=<.001
No longer making a contribution to society	64 (17.7%)	44 (29.1%)	72 (30.9%)	17 (20.7%)	p=.001
Keeping up with medicine	78 (21.5%)	48 (31.8%)	83 (35.6%)	33 (40.2%)	p=<.001
Will not know how to spend my time	44 (12.2%)	20 (13.2%)	32 (13.7%)	7 (8.5%)	
Relationship with my spouse	45 (12.4%)	9 (6.0%)	24 (10.3%)	7 (8.5%)	
Future care of my patients	33 (9.1%)	34 (22.5%)	44 (18.9%)	15 (18.3%)	p=<.001
Don't have other interests	18 (5.0%)	11 (7.3%)	11 (4.7%)	4 (4.9%)	

Survey participants and interviewees and focus group interviewees (see the introduction and appendix for an explanation of the focus groups) had varying concerns around the subject of finances. Responses varied from concerns about needing to work until very young children were through college to having “insurance coverage for my younger wife.” Some anxieties stemmed from the recent collapse of the financial market. One physician wrote of having “no savings after 11 years of practice.” One retiree in our focus groups said, “Money is a worry but I have learned to live with less. I don't buy expensive anything. The car I drive is eighteen years old and I take it fishing. I pay income tax on \$60,000, \$70,000 a year and I'm happy. It's enough for me. Tennis balls are inexpensive.” Statements also reflected a fear about securing health insurance or the potential of not being able to work even part time because of malpractice costs. A physician shared: “One of our nurses [who has] been working in our office for 17 years came to me the other day and asked what we were going to do about health benefits when we retire. She did not want to work until age 65 so she wanted to know what we physicians have available for health benefits. She wanted the same. I said, We do not get anything. She said, You mean you're going to have to work until 65 or until you're eligible for Medicare? I said, Yes; we're not Ford, we don't have any retirement plan that's going to cover health benefits.” Another person said, “Clinton's plan to be able to buy into Medicare at age 55 didn't sound so smart when I was 54, but at 59 it sounds

fantastic. That is an issue that is keeping many people from retiring. Physicians and non-physicians are caught in the same health insurance trap.”

Some respondents feared developing new interests, but some mentioned the opposite: having too many other interests from which to choose so they might become “scattered.” While some feared lack of stimulation, others thought they might not be able to pursue the interests they love because of diminishing mental ability, particularly as a result of dementia. One respondent seemed to be reminding himself that one needs to “Use it or lose it (brain).” One was specific enough to write of having the concern that he/she would be able to “[learn] enough about blueberries to make the blueberry farm economically viable.” One feared developing a “guilt complex associated with being nonproductive.” Another wrote, “I really resented having to retire because I know the patients, I miss the patients, I miss the students. I don’t have my time filled as I would like. I exercise and play tennis and play a little solitaire and a little of this and that, but only half of my time is occupied. I have the other half to mope about.”

While some wrote they had fears about the health of their spouse or other family members, at least one wrote that he/she did “not want to become a burden on my family.” Some respondents wrote of their friendships and socialization, fearing they might suffer from feeling isolated. One wrote, “I have not cultivated an adequate number of friends with whom to do things in retirement.” Another wrote, “Most friends are doctors who are still working.” A third remarked he/she had a fear of, “transitioning to new ‘peers’ and finding new friends with similar interests.” Respondents also pondered both whether and where to move after retiring, and one was anxious about “changing to new medical care (physicians) and facility (hospital) in moving to [a] new community to live.”

Some people cited fears concerning their children’s response to their retirement. One interviewee said, “My husband also retired at the same time I did. Would my son be accepting of the fact that he now had two retired parents? He was just finishing high school and starting university and the idea that his parents were now old folks, was that going to be a big thing for him? It worked out fine.” Another said, “When I started planning retirement, my husband said, ‘I’m out of here, too’ and retired the month before I did. Our kids asked if we could still go on vacation. They were concerned about cash flow, which wasn’t a problem and we just had to reassure them. But now it has been three years and they’re delighted that their parents can come to their ball games and bring their saxophone to school if they forget it at home.”

Maintaining health was a concern for many. Many feared whether they would lose their “sharpness of mind.” One summed it up by writing that he/she feared “the general problems of the aged!” Still another wrote of his present state instead of what he feared for the future: “Too much energy to quit!”

Many respondents were concerned how they would miss patient care, using their professional talents, and having contact with colleagues. Many wrote that they enjoyed the practice of medicine and serving their patients. One commented, “Practice gives meaning to my life.” Another wrote, “Medicine is fun and useful.” One feared “having

to quit what I loved best. Remember, one can't do just a little FP, one must be prepared to cover the front." One did not plan to fully retire but believed that "getting part-time work is hard."

Some respondents bucked the trend, however, as represented by two respondents who wrote, "None of the above. (Retirement from family practice doesn't mean one stops living.)" and "No concerns. I am very happy with my retirement." Another retiree was so excited about retirement, he said "I had no fear. I was so thrilled to retire and get away from a beeper, and not have to leave the house when the phone rang. My kids were delighted. I had no fears. . . . It was totally excitement and relief."

Issues of Identity and Self-esteem

Many physicians face an identity crisis as they approach or begin retirement and this becomes one of the major hurdles to overcome. In fact, one of the most powerful predictors of how well a physician does in retirement is his or her ability to deal with these identity or self-esteem issues. Workaholics struggle to find a new identity that may be based on leisure or on something that may not afford them the status they felt in their work. After retiring, the challenge may become a choice between "I was" versus "I am." Thinking of oneself in terms such as "I am a fisherman, reader, and traveler," or "I am a music lover, coach, and grandmother"—rather than "I am a physician"—may require a major attitude adjustment.

Specifically, no longer being called "Doctor" affects different physicians in different ways. "I sometimes feel like Rodney Dangerfield, I get no respect," joked one. "I think I'm less and less called Dr. and more often called by my first name or last name, and that kind of gripes me a little. Associated with that is a feeling like you're not quite as productive an individual as you once were." Said another, "I never thought that I'd get to the point where my first name is Doctor. I have a lot invested in being the family doctor and not wanting to give up the ego trip of people hugging you and telling you how great you are and how much they want you." But another had a differing view: "There's actually kind of a secret joy in [not being called Doctor] though," she said. "I find when I do some volunteer work I don't tell people I'm a doctor, and it's really quite nice to have people relate to you on a totally different level. They're not treating you as if you're some grand authority on everything medical, they just relate to you as another person and it's really quite delightful."

"Sense of significance is merely a sense of being a person that matters and has not been relegated to the dump heap over the hill," writes Mark Holoweiko in his article, "Which doctors are quitting medicine?" "Boredom and disrespect are equal menaces" (1).

Contributing to the good of society is the dominant value that drives identification with medicine and that "sense of significance." Recognizing the power of this value and finding ways to feel useful to society determines how meaningful life is to the physician

in retirement. As one of the survey respondents phrased it, how can one avoid becoming “just another retired Joe”?

Female physicians seem more easily able to adapt to this change; some, though not all, in our focus groups determined that they had other equally satisfying ways of feeling useful to society in an identity separate from medicine. A few expressed what they thought the differences between female and male physicians might be. One speculated, “We identify with our roles as parents and grandparents more than males. We had the primary responsibility for childrearing while we were practicing. Our identity as *parent* is just as strong as the identity as *physician*. Once our role as physician diminishes we have another role that provides adequate identity and self esteem.” Another said, “I think men have really got to retire *to* and not retire *from* something. They have to really know what their other life is going to be and I think that’s one of the great problems they have. They retire from medicine. I never retired *from* medicine. I retired to be a grandmother and to enjoy another part of life.”

Developing an additional means of feeling useful to society during the practice years may be the key to overcoming the identity crisis. The following are some retiree’s quotes from the literature, the recent AAFP survey, and our focus group interviews, that reflect physicians’ feelings about identity and self esteem. “I am still a vital human being,” said one retired physician, “but sometimes I feel useless. I think I surely ought to be doing something more than I am doing.” Another retiree commented, “I don’t do more than three things in one day because that would mean I wouldn’t have anything to do tomorrow. It’s a lot of down time.” Said another, “I’m a little unhappy that I haven’t gotten more to do and I look around and what I see I don’t want to do. [Volunteering with] Meals on Wheels, I guess; I could take meals out to the country and such, but that isn’t real tasteful to me. I’d rather do something to use my head.” Said another, “I have such an attachment to my patients, it’s going to feel funny not being a doctor. Your whole relationship with the community or some of the community changes, especially people [with whom] you really feel that attachment.”

Working as a physician is deeply satisfying. As George T Anast writes (2), “You probably have a mildly romantic image of yourself as the noble physician who has selflessly cared for his/her patients and contributed immeasurably to the health and well-being of his/her community.” Although the image is probably true it is not a lasting one. Your family and close friends may help carry the memory but the community and your patients may not. To them your retirement means finding someone to take your place. This does not indicate lack of respect or love but a need for self-preservation.

Different physicians will handle this issue in different ways. “I appreciate not getting those night calls,” said one participant. “I appreciate not dealing with the insurance companies and all the hassles that occurred in medicine and I enjoy taking off like I did— 5 days in Canada fishing and doing some things like that, hiking during the week and stuff that I wouldn’t do if I were still practicing. I think that after that initial getting accustomed to it, I’m glad I’m not practicing anymore. I don’t want any part of it, although I enjoyed it while I was doing it. I don’t miss it that much.” Said another, “I

have been retired 4 years, have no hobbies, do not play golf, hunt, fish, play cards, and yet I love to read, travel with my wife, do some yard work, do nursing-home and home visits for the enjoyment they and I get out of it. I waste some time and enjoy every minute.” A survey respondent wrote of living on an island “where there is always something that needs you, and positioning yourself to be needed is most important not only in medicine but in retirement.”

One retiree, when asked how he maintained his self-esteem, answered, “I do a lot of bragging about my work in the third world. I look for opportunities to show people what I’ve been doing with slide shows at rotary meetings and other gatherings. That helps me a bit. I also make house calls in our retirement community, or they come to my place. I see three or four people a week [who] want advice. They usually see me to decide if they should see their doctor or check out the advice that their doctor gave them. That makes me feel needed.”

Physicians have always considered time to be a commodity in short supply and time-wasting occurs as offensive. Finding something to do that is worthwhile helps reduce the guilt associated with no longer being productive.

The Value of Optimism

Avery Weisman, a psychiatrist reflecting on his own retirement, describes the issues of identity, values, and pursuing alternatives in the following statement (3).

I would like to have retirement be a time of both reflection and enhancement, to make a contribution of some sort consistent with what I treasured in the past. And after so many years, the problem of maintaining a strong identity during an indefinite transition becomes no easier. Nevertheless, a so-called successful retirement can be guaranteed only as a hope, buoyed by values true to the past and future. It is not based on actual information about how retired doctors survive, or an educated surmise on what to look for and avoid, but simple on unwarranted optimism. This optimism means no less that an opportunity in transition, which seems never ending, except to others, to pursue what is worth pursuing, despite no more work.

Weisman’s statement certainly rang true when I reviewed our discussions with retirees. Those who seemed to be doing well with retirement were optimistic and positive, no matter what they were doing or the status of their health or that of their spouse. They had developed other interests and had a positive image of themselves. They defined what they valued and found purpose and happiness in that.

Vaillant (4), in his book *Aging Well*, noted the extent to which optimism and a positive attitude predicted success in retirement. How often do we participate in conversations

that focus on the negative with other physicians? Negativity breeds negativity and being positive breeds the positive.

You can read the newspaper or the editorial page in the medical society journal to get your fill of negativity. This usually will lead to more frustration as you, a retiree or near retiree, are not in a position to do much about the issues being discussed. One might adopt the attitude to leave the battles to others. Accept the things that you cannot change. Others may feel the exact opposite and may choose to use their now more abundant free time to take on a cause that they have felt passionate about but did not have the time to pursue in the past. In either case, this is the time to focus on your positive thoughts. If your spouse is in agreement, pursue the activities that will make you happy and feel good about that. What others think is not important. You are at a stage in life where your individual values and the activities in which you participate are a matter of personal preference.

Your life experience as a physician has given you a gift that you can share. You are invaluable to society because of your experience, knowledge, and rational approach to problem-solving. Volunteering or working part-time will make that experience available to society. A complete separation from being of service to others and not being acknowledged can be distressing. Being of service in some way provides a means of maintaining self-esteem.

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CHAPTER 4: Relationship with Spouse or Significant Other

“I now have twice as much spouse and a third as much money.”

Retired physician’s spouse

“Well, we’re married 36 years and we love each other . . . but too much of that is too much of that. She wants time to herself. So she’s saying to me, nice to see you in the morning and in the evening and when we’re on vacation . . . but I’ve got to have some time to myself the rest of the day. So if she wants to go out to lunch with other people. . . that’s healthy. [We sometimes joke] ‘I married you for better or worse but not for lunch.’”

Retired physician

One of the biggest surprises that physicians have after retiring is discovering that their relationship with their spouse changes. They now may relate through leisure and other shared activities as opposed to a construct where one is a busy practitioner struggling to find time for his (or her) family. Involving one’s spouse in the planning process is of major importance. Spouses have their own agendas, and for some retirees, making peace with the idea that their spouse’s agenda differs from their own can be a challenge. You may find out in pre-retirement conversations that your spouse may not want to retire or change much of his/her daily routine. Negotiating with your spouse can be time-consuming, but your happiness is worth the processing that it takes to distinguish what you both are thinking and feeling. What will come next? Discover what common ground exists and where the potholes lie. Before announcing your retirement plans to family and colleagues, be sure you and your spouse agree on the plans. For some couples, disagreements and diverse agendas regarding retirement issues have been one of the factors that have led them to divorce.

The Harvard Study of Adult Development, reported on by psychiatrist George Valliant, MD, in his book *Aging Well* (1), was the longest, most comprehensive examination of aging ever conducted. Researchers have studied more than 800 men and women since the study’s inception in the 1930s. Subjects were followed from adolescence into old age with the overall intention being to elucidate what behaviors translate into healthy and joyful longevity. One couple interviewed in the study said, “I just love the weekend days with my wife. We go on little adventures. Last week we drove to Vermont to look at covered bridges. I depend on her for love, confidence and judgment. I depend on him for devotion and leveling me out.” Another couple stated, “We don’t hold grudges and we try to comfort each other. We have had a number of deaths in the family over the last couple of years and we turn to each other for support.”

When asked about the most important thing that makes him want to get out of bed in the morning, an 84-year-old study participant said, “To live, to work, to learn something that I didn’t know yesterday, *and to enjoy the precious moments with my wife.*” A 78-year-old subject answered the same question by saying, “All the many plans for the day. I love life and all I do. I love the out of doors and it is a joy to be alive *and living with my*

best friend, my wife. Another man interviewed in this study stated that he and his wife led different lives. “We have different passions,” he said. “I don’t impinge on her work. We still do a lot together—breakfast and supper . . . our daily walk and our garden.” A retired CEO of a small company stated his chief task now is to help his wife do her work with the local Sierra Club. She is the chair of a committee and he is the “gofer.” He was very proud to be doing the analysis and background work for her project on hazardous waste. Another couple said, “We are best friends and we enjoy taking care of each other.”

Changes: Both Partners Must Adjust

Retirement can be a major challenge for the spouses of retirees. For spouses who have not worked outside the home (largely represented by women),** the physician has gone off to work every day and his wife has been fairly free to schedule her days as she wishes and needs. Suddenly, post-retirement, the husband is home every day and the interests of the two can differ markedly. Interviews with retired physicians or their spouses divulged a number of important issues. These include cases in which couples have grown apart in their interests or cases in which a spouse now wants to pursue new interests and independence because the physician can take more responsibility in domestic matters.

Spouses reported a number of changes after retirement, but foremost was having their physician wife or husband at home more of the time. “A lot of things that I didn’t like to do, I send him off to do,” said one woman. “I hate [grocery] shopping. When I was growing up in the mountains we only went shopping once every 2 months and stocked up on everything. I just give him the job of going and getting weekly things because I hate it so.” Some spouses noticed the difference when their physician partners were more able to do things they had no time for before retiring. One wife mentioned her husband now had time to read the newspaper: “Before he would just read the headlines and be off to work. Now he reads the paper from front to back. He also now has time to read the medical journals and all that material he had stacked in his study.”

Couples find that when the working physician retires, there is now room to share tasks that were previously the general responsibility of only one of them. As one retiree shared, “We quickly adjusted to the idea that whoever gets up last makes the bed. If we get up together, we make it together. She loves to cook so when she finishes cooking I am the clean-up man. She loves to entertain, so when she does all that work I do my portion. But she’s also very good at business management, so she helps with the books. I don’t know; we just seem to be getting along fine.”

A 2001 survey of post-retirement Texas physicians (2) reported that 44% of participants rated their relationships with their spouse to be improved after they retired, 51% experienced no change in their relationships, and 5% considered their relationships to have worsened. These physicians also felt that their spouse’s loss of health was more stressful than loss of their own health.

* Over 80 % of family physicians over the age of 50 are male. In the recent AAFP study, 90% of the respondents were male; we have few quotes from male spouses of physicians.

“I think sometimes physicians outgrow their wives or vice versa,” said one interviewee. “The physician is ready to retire and stay home but the wife is ready to go and do her thing. She may want to go back to school and get an advanced degree but he’s going to be home now and he doesn’t want her to be gone.” Said another person, “You’d think [if] you live with someone long enough you would be able to anticipate any problems. We have physician friends who are still working because they want to stay working and their wives want them to stay working. The wife has been very independent . . .” “I took care of a number of physicians and their spouses during my practice,” shared one retiree. “The comments I would get from one or the other when I would see them by themselves indicated that they had little in common other than their children. And when the children leave home and the physician retires, they may go their separate ways either emotionally or physically.”

Many physicians shared that their relationships had improved post-retirement. “We’re together more, we’ve been able to travel together,” said one female physician. “My husband retired some years before me. He was able to go on longer trips, and now we can both go.” “We have so much more time to talk to each other,” said another. “Not just about how was your day, and sorting household issues, but actually interesting, in-depth topics—things we’ve never talked about in the whole time we’ve been married.” Another echoed this view: “It’s just much better, it’s more fulfilling. It’s been wonderful to have this time together and discuss a local or world event instead of [just discussing that] there’s a load of laundry in the washing machine, make sure it gets to the dryer.” Some interviewees connected their better relationships with no longer being as tired and stressed from medical practice; they felt much more free.

For physicians who have been unhappy, burned out, and possibly depressed while they were practicing medicine, retirement may bring a dramatic change of mood. As one retiree stated, “My wife was delighted [when] I decided to retire. . . . I was burned out. It took me 5 years to finally admit it. She now likes me better and we get along much better.”

Spouses and retirees remarked on the ability to spend more time with family as a couple. “In the spring, we had a quick trip to pick up our granddaughter from college,” said one wife. “Then in January, we took a cruise through the Caribbean. That’s all that we’ve gotten into this year. We’re not into skiing and mountain climbing. Reunions, we seem to go to a lot of family reunions. Our family has always been important.” “We have three granddaughters,” said a physician. “I’m very involved with them because of their music programs. I’ve done a lot of kid-chauffeuring, so that’s kept me very busy right after I retired and now he’s doing it. He is chauffeuring the big bass and the child that plays the bass around. The school programs just need volunteers so badly. There’s a void in there in people from 3:00 until [other] parents get off [work]. I also took kids for a swim group. I had to pick them up at seven, a carload, and take them to the pool and then the parents could pick them up at seven. So, we both volunteer to help our grandchildren as well as other children.”

Many spouses and retirees spoke of meeting new people and taking on new interests. “My husband actually retired thinking that it was going to be quite difficult to make friends,” said one wife, “but he has done some volunteer work in the new community that we’re in and has some hobbies. He’s a stamp collector and he’s managed to develop a network of people that are not medically connected at all, and that’s worked out okay.” Others mentioned making new affiliations with groups and communities, including medical groups. “I still stay active in the medical alliance,” said a retiree whose wife was his office manager. “I keep up with all the political aspects of medicine and all the gossip. The alliance has meant a great deal to me—an important part of my life. It is nice to have my little meetings.” This man’s wife spoke of the importance these meetings had for her, as well. She said, “My husband was a delegate to the AAFP for several years. I enjoyed meeting people and the social activities at the [AAFP] meetings. I also enjoyed some of the lectures . . . It gave me a better understanding of the challenges of being a physician.”

Spouses of retirees have some fears and concerns in common. One woman complained that her husband slowed her down. “I have plans for a sewing project or redecorating project and need some alone time to do the planning,” she explained. “We have recently moved, downsized our housing, [and] I have a whole catalog of things I need to do. I feel guilty if I do those things while he is around. It’s great when he gets out of the house for a while.” While many retirees fear their own isolation or depressive reactions to retirement, their spouses sometimes harbor the same concern: “Well, I wouldn’t want him to become an island unto himself. . . . All of a sudden, you’re away from your colleagues, away from your patients, who are a great part of your life and it leaves a void there.” Another interviewed spouse spoke of having fears about her husband’s health. “I was looking forward to the time when we could retire and we could do some of the things that we planned to do but his unexpected surgery has put a curtailment on that, so it slowed things down a bit. But we can still do a lot.” Another interviewed wife, who had herself retired as a physical therapist 5 years earlier, feared her husband’s potential inactivity after retirement might lead him to become “locked into himself.” “He could go and sit on a fishing bank 5 days a week and that would be enjoyment for him, but he’s not had that opportunity. He would like to do that, but we’ve kept him too busy.”

Words of Wisdom

In describing the results of the Harvard Study of Adult Development, Vaillant (1), the study’s director and a senior physician at Brigham and Women’s Hospital in Boston, said the data showed that a good marriage at age 50 predicted positive aging at 80 (but a low cholesterol did not). Vaillant felt that generativity, commitment, tolerance, and humor were the four keys to a contented, long marriage.

There are many words of wisdom that retirees offer about the challenges involved in one’s marriage after retiring. Respecting each other’s need for individuality and not being threatened by that individuality are important ingredients of success. The changes associated with retirement for the physician, especially the male physician, can be overwhelming. Being in charge and feeling in control of your life and those around you

has been his *modus operandi*. Some physicians who are not able to adjust to the loss of control and who can find no replacement for that feeling may look to their home and their life partner as the new focus of their need to be “the boss.” This may manifest in subtle or obvious ways.

For instance, one physician sounded a warning in relaying an anecdote of a retiree with too much time on his hands. The husband of one of his patients had recently retired. “She was out for the afternoon and when she came home, he had rearranged her entire kitchen because it was ‘inefficient.’ She couldn’t find the pots or the silverware. He then had the unmitigated gall to ask, what’s for dinner?” Other interviewees told amusing (and undoubtedly) frustrating stories of “women who say ‘my husband retired last year and he’s driving me crazy. He just follows me around and says, what are you doing that for? Why don’t you do it this way? Why don’t you do that?’ I think that doctors really have to know what they’re going to do when that door shuts.”

If you are one of those physicians who is at loose ends without the structure of your career, your spouse is likely to notice it first. Increased disagreements, signs of depression, and acting out behaviors are all symptoms. Unhappiness and discontent with retirement will surely follow.

If the marital relationship was effective before retirement, it will probably be easier to get through this stage. If the marriage was already a struggle, this stage will be more of a challenge. Realize that you and your spouse need to continuously discuss differences and work out compromises; this is just as important in retirement as it has been previously during your marriage. Schedule periodic meetings in a neutral setting when you both are feeling at your best. For some people, this time is in the mornings immediately following a walk. The couple begins the discussions during the walk and finishes them during a breakfast that they have prepared together. One tip is to schedule a romantic evening at a nice restaurant the evening before a scheduled discussion as this can set the stage for partnership.

Physician retirees had varying observations and tips about relationships for their colleagues who were considering retirement. “Continue on with interests that you had before retirement,” said one. “I still do most everything that I have always done. I now have a little more time to do it as I now have a partner to help me out.” “I think [relationships with significant others are] a big issue for retired people,” said another. “I hear [about] that from many women [retirees] who are used to having their independence. They’ve had a lifetime of a sort of balance of how much time they spend [with spouses] and how much time they’re apart, and they’re not necessarily going to be able to cope with all that constant time together.” One wife whose retired physician husband was coming to grips with the domestic responsibilities of the couple’s life, said, “He mentioned to me this morning that he did not know how he found time to work before retirement. Well, he had time to work because I was doing everything household-wise that he didn’t have time to do. The yard and garden and other household chores were all up to me. So, that is a difference now. I just send him to do it. When he starts to pace, I find something for him to do.” A retiree cautioned: “Don’t expect your wife to give up

her activities now that you have more time around the house. Blend with her schedule. I don't play golf, but she always has, so I drive her golf cart.”

Do not make assumptions about what your spouse thinks or wants. Be humble in your requests and expression of desires. Some spouses feel that they have sacrificed for you, their physician spouse, for many years and it is now time for them to enjoy themselves—and that enjoyment may not always include you. Some spouses may have felt for years that they needed to be at your side to help you handle the stress of patient care. Now that you are free of that burden, so are they.

Be prepared to find something to occupy your time that is independent of your spouse. Chapter 5 provides some good options to consider for how to spend your time in retirement. However, do not commit to any major activities without discussing them with your spouse. Discussions about how you both will spend your time after retirement needs to take place 2 to 3 years before the first spouse retires. Get a feel for the likes and dislikes of your spouse. Spouses who say they don't really have preferences, that an activity or plan “doesn't matter” should be questioned in this regard to ensure they are fully expressing their needs and opinions. Find out how much of *her/his* routine your spouse wants to continue in *your* retirement. Remember, unless it is negotiated as such, it may not be *our* retirement.

Things may change with time, and therefore the negotiations must continue. The inevitable will happen with your health status and that of your spouse. Each one of you may feel the need to change. Your spouse may have a job that he or she finally wants to give up. This may be especially true in dual professional marriages. This may now produce a new challenge. Your spouse may now be in the same predicament you were in a few years previously. You are now settled into your retirement “role” and your spouse now wants to renegotiate that role. The principles of flexibility, negotiation, and continuous compromise need to be the watchwords of your retirement if it is going to be an ongoing success.

Getting along with your significant other will depend on your ability to effectively communicate. You may have thought that your communication was already effective but the reality may be that your spouse only tolerated a certain level of communication because your time at home was limited (3). You may find that the increased time you now have with your significant other is laced with more emotional outbursts or maladaptive behavior. You may need to develop a new style of communicating, and that is often easier said than done. In fact, it may be difficult to achieve without some outside help. As can be noted by the above anecdotes and comments, spouses need their space. As will be noted in Chapter 7, as people age, one the major determinants of whether they feel satisfied with their lives is whether they feeling in control (or at least, in charge, as much as possible) of their environment. Your significant other must feel that they can control their environment and have their space. They may be having difficulty communicating that to you.

Weekly “business” meetings between partners, which allow ample time for each

individual to express feelings, go a long way toward preventing communication gaps.

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Chapter 5: How to Spend Your Time in Retirement

“Find a compatible second career including service to others that challenges your capabilities. Keep up your interest in your community, your church and all other organizations that are important to you. Take courses at the local community college in something that interests you. Travel and spend time with your family.”

Advice from a retired physician

Upon retiring, you will no longer carry official job titles and devote long hours to being a physician. In addition to thinking about yourself in new ways, you need to think about different activities to look forward to each day. Retirement is a great time for self discovery. Realize the power within to take charge and create opportunities for enriching activities and exciting leisure pursuits. Most retirees advise staying involved and busy, and focusing on the present and future rather than the past.

Betty Friedan (1) offers the reassuring vision that old age can be “a fountain of inspiring activity.” She believes that many of her friends use their skills to an even greater degree in retirement than they did during their pre-retirement years.

Finding productive ways to spend your time is one of the major tasks in both retirement and its preparation. This chapter addresses some of the issues involved in how you will spend your time, and includes many anecdotes surrounding the experiences of the pre-retired and retired family physicians we interviewed. Read in this way, you can consider these suggestions for your own retirement activities.

Know the difference between high quality of life and a high standard of living. Quality of life has nothing to do with electricity or operating a computer. Quality of life can be said to be more of an appreciation of the sights, smells, sounds, and people around us (2). We may have been too busy to notice most of this while we were in practice (‘Too many lives to save,’ you know.)

Look at the view outside your window or the countryside that you have been driving by for the past 10 years. Take a walk downtown, smell the aroma of freshly baked bread, and look at the beautiful people who may be walking nearby. Go sit in a coffee shop, continue your people-watching and observing life’s different forms of beauty. As you walk back home, or to your car, stop and draw in the scent and colors of the grass and trees, flowers, and, perhaps, vegetable gardens you may see along the way. The simple things in life have much to offer in your decisions of how you will spend your time after you stop working (2).

The Decisions are Individual

How physicians spend their time during retirement varies from person to person. A survey of retired Texas physicians (3) revealed that 8.5% participated in some type of compensated medical practice, 8% performed compensated medical-related work, and 11.5% did medically related volunteer work. The amount of time spent in the above activities ranged from 6 to 15 hours a week. Forty-eight percent of these physicians participated in other activities, including travel, reading, taking classes, writing, painting, and poetry. Sixty-three percent of the group felt they could engage in moderate physical activity.

The following are comments and advice from the pre-retired and retired physicians who participated in the recent AAFP survey and our interviews, on the subject of how to spend one's retirement time.

“I now teach physiology in a community college but will take off some semesters to travel or do a home project. I am a free agent. I am doing about 70% of what I used to do but have 90% fewer hassles. I have become a part-time Hospitalist for my old group. Do it about 2 weeks, every 6 weeks during the day but no night call. This gives my group a break when someone wants to go on vacation. It also allows me to see some of my old patients and give them care. I also have the luxury of sitting in the physicians' lounge or the cafeteria for an hour and a half and [I] shoot the bull with friends and watch others come and go as they are too busy to spend time together. I am now CEO of DS—*Chief Executive Officer in charge of Diddle Squat.*”

“We have about a dozen of us retired in this area that get together for lunch. I sure look forward to getting together every month. It's been pretty rewarding as far as collegiality and getting together with people you haven't seen for a few years. It's helpful for all of us I think. We talk about what happened to the other guys that retired with us. Each one of us has a bunch of questions for the rest of the group about their own medical problems. We talk about our golf games and our grandchildren and a few things like that. It just seems like the time passes very rapidly.”

“I have other work to do; I'm not in a position where I don't have enough things to do. I actually want to do some work as the medical director of our group and do some quality [assurance] work and things that I like doing. I have the opportunity to do a lot of speaking in different areas and people are calling me up for that kind of stuff, but it doesn't quite replace the emotion of the patient contact.”

“Medicine is a very jealous mistress but I think there are a lot of other things in the world and retirement gives you an opportunity to pursue some of those things that you've had to neglect because of the demands of medicine. . . .

I guess I'm the kind of a guy that maybe has a psychological harem. I have boating as a mistress—damned near as demanding as medicine—and medicine is a mistress, and my wife is my first love, but she says she feels like she's one of the three mistresses.”

“My wife and I are both 53. I hope we'll be able to go visit the kids and the grandkids. At the same time there are some other things that are available to do. Some of the retired physicians in our area work for the hospital doing what they call quality assurance. They call and try to get patients out of the hospital sooner. I have a real negative feeling about that. I also might volunteer at the numerous free clinics in town, or teach at one of the three residency programs in town.”

Hobbies were touted by many to be a saving grace and a retirement blessing. Retired physicians who took the AAFP survey and those whom we interviewed have found many interests to occupy their increased free time. Some of the hobbies mentioned were bike riding, golf, pets, gardening and yard work, Coast Guard Auxiliary, restoring antique boats and cars, sailing, photography, writing, and computers. A number of retirees joined local organizations, such as the public library, art museum, historical society, church groups (including the choir), garden club, charitable foundations, and the AARP. One retiree spoke of his former partner, who is keeping up his love of carpentry. “He always did a lot of it before he retired,” his friend said. “He made all our office furniture when we started the practice. He loves to do cabinet work. He does it for his kids' house now.” Another interviewee contributed, “I was looking for the hobby that keeps me mentally stimulated. I guess it's the computer. I've been working for 20 years with a computer and I fiddle around with one thing after another on it. I do a lot of e-mail and word processing and financial. I keep up on all the financial aspects and then I do a lot of utilities and fiddle around with things, and I try to fix something that goes wrong and sometimes I [succeed] and sometimes I don't.” These physicians believed that pursuing one's passions is a good way to steer clear of boredom. “I have continued part time teaching and service to [the] underprivileged,” said a second, advising, “[I] stay active physically . . . travel, attend cultural activities, read, participate in my hobby— photography (I have exhibited my photos)—and follow my investments carefully on the Internet. I have no time to be bored. I wish there were more hours in the day to do all the things I want to do.” As another antidote to boredom, one physician advised, “Stay involved; use your brain. I go to AAFP-approved CME every week. Get physical exercise ½ - 1 hour daily. Enjoy your children and grandchildren. You don't retire, you just don't get paid. I call it pay back time.” “Develop other interests early that are expandable after retirement,” said another, but cautioned, “Don't let concerns about boredom cause you to overload your early retirement schedule — you'll find there's plenty to do.” One physician summed up her activity by saying, “My practice was a success and so is my retirement!”

Think about how you feel at cocktail parties or other social gatherings. Are you the last one to go and love talking to people (extravert)? Or are you the first one to leave and feel exhausted from all the stimulation (introvert)?

Gender Differences

Some of the female physicians who were interviewed believed that as a rule, men preferred physical activities such as golf, bike riding, or tennis as opposed to quiet hobbies such as reading or music. These activities require good weather, physical health, a partner, and more preparation. With a change in the weather, health status, and the health status of your partner, you may not be able to participate in these types of activities. Quiet activities are usually weather-proof, can be done by oneself, and provide an inner peace and joy. The ideal is to include both types of activities in your life. It is important to note that many women do enjoy physical activities and many men enjoy quiet hobbies. Perhaps the gender difference is generational. With changes in funding for women's sports, young women are more physically active today than their mothers and grandmothers were. That trend will most likely persist into their later years.

The female retirees we interviewed believed it was easier to occupy their time after retirement because their identity was not exclusively tied up in medicine. Their roles as mothers, spouses, and homemakers provided additional strong aspects of their lives during the practice years. When retirement came along, it was natural to build on these components of identity and find ways to spend their time. Much of the advice given by these women is applicable to men as well, however. As noted in our survey data, spending more time with family was a reason for retiring in 40% of the women compared to 27% of the men. Younger physicians also were more interested in spending time with their families; 34% of those aged 50 to 59 listed this as a reason for retiring compared to 21% of those over 70. (See Chapter 2, Table 2, page ____).

Many female physicians found family to be a grounding rod and activities arose from caring for their relatives. "I didn't know that driving the car pool to the museum or the field trip was going to be so much fun," said one, and another said, "I coached my granddaughter's soccer team with another friend and it was a great time." "Just staying home with the family and containing the chaos was worthwhile," commented a third. "It rejuvenated me. For men I do not think that's true. They needed to be out of the house doing nothing or playing golf or tennis to recharge their batteries." One female retiree said, "I moved closer to my daughter to become a full time grandmother. When I counseled patients about retirement, I always advised, Don't retire *from* something but *to* something. I was retiring to another lifestyle. I thought it was all exciting; it was another adventure."

Many female physicians adjusted to a life after retiring with more family time. "I travel more with the kids to their sporting events," said one. "Before, if the event was more than 2 hours away, I could not be that far away from the phone." Said another, "I have only one grandchild and I am this grandchild's only grandparent. So I felt it was

essential for him to learn something about grandparents. One of the things I learned at his nursery school was how much young children miss having grandparents around. One little child came up and hugged me around the knees and said, 'You always come and visit Ethan, I wish my grandmother came.' It felt so tragic. I was wondering, if that grandmother could have heard her grandson say that to me, what she would have thought. I have no regrets. I consider myself a full-time grandmother. If my grandson wants to do something, that's what we do."

Some additional advantages of retirement come from new time schedules. "Instead of exercising at 5:30 in the morning as I did before retirement, I now run at 9:00," said one person. "I don't know that my activities changed much but it's certainly at a much better time. I'm also doing a lot of gardening and started cooking more. I actually now make a good dinner, sort of the way my mom always did." Said another, "We found it very nice to be retired so that we could take advantage of some of the special last minute [travel] deals now. You didn't have to plan your holiday 6 months in advance, you could kind of go on the spur of the moment . . . We bought a condo, actually, when we retired and [now we] just close the door and go." Another female physician remarked on how a difference in time management contributed to the quality of life: "There seems to be so many other things in life to explore, like reading, playing music and socializing with people. The quality of conversations is different once you don't have to rush in the hallway. I can now make an arrangement to go out with a friend . . . and linger over coffee for 2 hours if I want. I really enjoy the quality of what all these different things in life offer now." Said another, "I feel like I worked 40 years in twenty. Those were the kind of hours I was working." Another related, "For men [when they were practicing], time off was time off. A woman's time off was family time or time to do other chores. One night I remember coming home after delivering a baby in the middle of the night and doing my grocery shopping at 2:00 AM at a 24-hour grocery store. I could not go down the aisle where the cereal was because they were waxing that aisle. I burst into tears because the next time I would be able to shop for cereal was going to be another 7 to 10 days."

Many female physicians commented on experiencing an upsurge of energy post-retirement that made doing more activities possible. "When I was working I just wanted to be alone a lot on weekends. Seeing thirty patients a day and dealing with colleagues and employees was exhausting. By the weekend I just wanted to nest. Being retired has changed all that. I am not tired on weekends. I actually have more time for my friends. We get together for cards, lunch, and other activities." "My physical activity increased tremendously," said another. "We do a lot more as a couple."

Some of the activities mentioned by these women were cooking, gardening, crafts (including sewing and quilting), redecorating, many types of exercise, rebuilding a greenhouse, and horseback riding. One female retiree echoed others who were now studying languages and taking up interests they'd left behind earlier in their lives: "I take a Spanish class, that's great fun. I am doing all the things I would have done in my 40's and 50's had I not been up to my neck in work. I feel like I've put so many things on hold for so many years that now I want to do them and I don't want to go backwards and put them on the back burner again." Others found their interest in medicine was

vitalized: “I went to the [AAFP] Board Review course a year ago in Kansas City and just sat there for 53 hours,” said one physician. “I was just mesmerized and it was so much fun to relearn or to hear it again. I enjoyed knowing that I did not have to go back and miss sleep and do more paperwork to make up for the time away from practice.”

Volunteering

Physicians have always graciously volunteered their time and skills to provide care to patients who lack the means to afford their care. They volunteer their time in their private offices, free clinics, and through other activities organized by community organizations. They have done this while they are in active practice, and have an active medical license and malpractice insurance. But once they retired, malpractice liability and licensure can be a barrier to volunteerism.

Policymakers across the country have attempted to address this barrier. State laws historically control liability issues in malpractice, but the desire to prevent the fear of lawsuits from stifling charitable volunteer activities stimulated Congress to pass the Volunteer Protection Act (VPA) in 1997. This resulted in the creation of some liability protection for all volunteers carrying out charitable duties throughout the United States.

Many of the physicians we interviewed kept their medical license for a few years after retirement. Some did so because they thought they may want to return to practice and others because it was needed to do volunteer work. They considered that license to be the last evidence of their personas as practicing physicians. But the cost of maintaining the license can become a burden as the cost of living increases and one’s income becomes fixed.

Medical licensure issues vary by state. Some states such as Florida will allow you to maintain your license at no charge and provide immunity similar to that provided for other state-employed physicians. The physician cannot be compensated for any of the care provided and the care must be provided at one of the State of Florida-designated clinical sites. Other states will reduce the fees and some states have no provisions for reduction of fees. Some insurance companies also provide reduced rates. As more physicians are considering volunteering their time, some states are reconsidering their options. The Appendix contains more information about Charitable Immunity Legislative Information (see page ___). This document reviews the status of most states regarding malpractice coverage when volunteering. Do not rely on word of mouth to decide whether you are able to obtain reduced or no rates for volunteer activity that you provide at no charge. These laws have changed over the past few years and are in the process of changing. Contact your state medical society and or your state licensing board to be informed of the latest information.

In our interviews, we found that some physicians were not knowledgeable about their own state's recent legislative changes in this regard. After you inquire to your state medical board or medical society, if you discover that your state does not have a charitable immunity law and or license relief, contact the executive director and officers of your state chapter of the AAFP and ask them to lobby for change.

Our interviewees had many comments on the availability of volunteer activities for physicians. Some of them came to recognize the many new opportunities were practically knocking on their doors if they were aware of them. "We have historically, through the years, been curb-stoned at every cocktail party and golf club." Someone comes up and says, I got this or that and I do not know what it is, or is this the right treatment? There is a need, even a niche for medical interpreters or coordinators for people who have complex medical [conditions]. Their physicians just are simply not [going to give] or don't have the time to integrate and translate everything that's going on. Translation may be a role senior physicians can play."

Some retirees mentioned giving lectures or leading informal discussions at their local senior citizen centers on health issues such as immunization. One retired physician who took the AAFP survey wrote a number of ways that he does medical-related volunteering: "I interview applicants for the medical school and sit on [an] admissions committee that meets every week. I sit on two hospitals board of directors; Health Alliance of CNY for health, care delivery; board of directors of one nursing home; board of directors of Home Aids — nonprofit co.; chairman QI/QA committee for Home Care Infusion nonprofit; board of trustees at church; admissions at community college; medical school clinical faculty. Many other people-involved activities: e.g., retired programs." "One of the things that I think I'll do in the future," commented a physician about his post-retirement volunteering plans, "is Habitat for Humanity, go out and paint a house. Go elbow to elbow with Jimmy Carter." Said another retiree, "I was on the zoning board in my old community for 25 years and when I moved I called up the mayor in my new community and said, I'm here with all of this experience can you use me? He said, Wonderful! I'm now an alternate on the zoning board even though I've only been here less than a year."

Robert Heerens, a family physician who valued patient education during his practice years, now gives informal presentations to residents of retirement communities on health issues that face seniors (4). Heerens's encourages questions from his audiences about the health issues they face. "People my age often get caught up in being depressed because they can't do anything or don't feel like doing anything," he says. "I try to explain how something as simple as your attitude can either help or hinder your health. I try to show how to manage an illness, not suffer from it."

Our interviewees had much to say about the value to physicians when they volunteer. "There's probably a definite body of retired or about-to- retire physicians who would constitute a resource, if that resource were nurtured and guided or directed," suggested one interviewee from our group. "I'm sure they would be very willing to share their experiences." Others spoke of the specific value for medical volunteering. "I volunteer

in a free clinic for 3 hours every Tuesday night. Medical volunteering helps me use what's left of my skills and it keeps me a lot happier than the rest of the retirement. I can't play that much tennis or golf and it's boring if that's all I do." "Well, I think we should look outside of medicine for things to do," commented another. "Some of that's the direction my friends are taking. Options are more than just seeing patients and dealing with medicine." "A lot of my colleagues are very, very active in the community, volunteering for different things here and there," said one person. "It gives the physicians themselves a sense that they're going ahead with their lives even though they're retired. I was amazed at how many are doing volunteer work."

Other comments on volunteering, both in medical and non-medical situations, follow.

"One of the things I like to do is locum tenens for one of my old friends. His practice is easy. He only has a daytime practice, nothing at night. I do it, not to make the money, just to keep active, maintain my skills and keep feeling good about myself. There are companies that will provide locums for physicians but this is very expensive. The rural family physician can not afford it, but is willing to pay some amount to one of his colleagues. So both parties benefit by the arrangement."

At present, I'm doing lots of medicine-related volunteering. I interview applicants for the medical school and sit on [an] admissions committee that meets every week. I sit on two hospitals board of directors; Health Alliance of CNY for health, care delivery; board of directors of one nursing home; board of directors of Home Aids — nonprofit co.; chairman QI/QA committee for Home Care Infusion nonprofit; board of trustees at church; admissions at community college; medical school clinical faculty. Many other people-involved activities: e.g., retired programs.

"I've been heavily involved in our housing association on the environmental issues and commercial development impinging on natural wildlife areas. Quite evidently from what I hear from others, I have engendered a fair amount of respect in that area. I haven't gone into it to maintain any self-esteem or anything, but I went into it just to maintain the purity of the wild area near which we live."

"I'm the Treasurer [for] the Attention Deficit Disorder group. Sometimes it gives me satisfaction and sometimes it gives me some headaches. A lot of the people in the group have ADD. It sometimes can be a challenge working with them, but is for the most part very gratifying."

"When one of our older guys retired, one of the things we did is we had him come back and work in the office when too many people took off on vacation or were off at meetings and rather than paying him we used what he produced to do two things, we paid

some of his expenses for CME, we paid for some of his dues and it also gave him a chance to get some health coverage until he got to 65. [We paid his malpractice insurance] but he was only practicing part time so the malpractice insurance was literally set at a part-time limit . . . He didn't get any direct compensation for that, but we received the benefit of him being there and seeing people and it was in his first 2 or 3 years out after he retired but in the same respect, gave him a chance to do something.”

“I think of what my overall role is, what I want to do. I've been seeing patients for a long time and I like seeing patients. But I like to think of my role as serving a different layer, like serving doctors, maybe, or serving health kinds of things, not disease kinds of things, or serving community structures. Just kind of raising the bar a little bit.”

“I think volunteering in a hospice locally is a kind of way of keeping in touch with patient care without having to be responsible for the patients. I act as a companion, make tea, sit and talk with people, take them for a walk with the wheelchair and that's been a wonderful way of keeping some of the environment of caring or giving without the need to be the doctor.”

In addition to these many suggestions offered by the retirees who were interviewed, I have included a few books you may find helpful when considering options of how to spend your time. *How to Create Your Own Super Second Life* (5) provides 200 suggested activities as well as worksheets and forms for planning purposes. Included are discussions of how to take action on pursuing your dreams, tools for reducing conflict and busting through inertia, and means to perform periodic review and modification of your plans. *How to Enjoy Your Retirement Activities From A to Z* (6) has a number of worthwhile suggestions. The book provides a brief alphabetized description of activities that include, for instance, art, aquariums, hiking, libraries, travel, sister cities, writing, and zoos. An appendix includes valuable Web site URLs and addresses for state boards of tourism as well as other information of value to the retiree. Appendix B on spending time with grandchildren provides special activities that might interest children and grandparents both.

After reading this chapter and perhaps a few of the suggested books, you will no longer need to say, “What am I going to do when I retire?”

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Chapter 6: Closing Your Practice

Closing or separating from your practice creates multiple challenges. The psychological issues of separation from your practice and staff, coupled with the pragmatic and legal issues of closing your practice, can be both confusing and stressful. Some of the challenges that will be addressed in this chapter include dealing with your colleagues (if you are in a group practice), finding a suitable replacement, notifying your patients, appropriately disposing of medical records, managing your accounts receivable, and making appropriate arrangements for your employees.

Physicians we talked to had some useful advice that they'd formulated through their own experiences of practice closure. "I retired from a group practice and we had in force the following rules regarding voluntary retirement from the group: Only one member of the group could retire per year, a one-year notice was required, the date of commencing retirement would always be June 30 to increase the chances of recruiting a graduating resident and you had to help find your replacement." "You need at least a year beforehand [to start closing your practice]," said another. "I found that it was much easier to find one of the local hospital groups to buy out my practice. Trying to sell to an individual [physician] looked like a pretty impossible task. . . . [I]t makes it so much easier [to sell to a group] because they've done it before and they can do most of the work for you." One physician who was closing a practice thought it was easy for him but much harder for the staff. "The secret was having somebody buy you out, come in there and assay your equipment, buy your equipment—I never could have sold that stuff without somebody like that."

One physician we talked to offered a number of tips, which I have placed in the table below (Table 1).

Table 1.—Tips for closing your practice.

Make a schedule of needs: immediate notifications, dates you can dispose of records, etc.
Bundle records or other information that can be discarded by the year it can be discarded.
Keep a list of patients seen by you and where records go.
Do not give original records to patients, offer to copy them. If records are voluminous, it is acceptable to charge a small fee.
Keep a record of where records were sent.
Notify patients as far ahead as possible, but don't cut off your [patient] trade too soon.
List on each set of records the number of years your state laws will allow legal action (exceptions for children) so you know when it is allowable to dispose of them.
Provide for patients a list of physicians to consider for your replacement, but do not give out specific names. Some patients may prefer one gender over the other. Insurance plans may also have similar lists.
Only write or type in your record what you want known to everybody. Otherwise, it is between you and your patient.

“*Medical Economics* published some steps and a timeframe for closing your practice,” said one physician (1). “I pretty much followed their suggestions. Sending out your announcements to your patients and lining up some continuity for [them] can be done in a variety of ways. . . the thing that I was most concerned about was finding some way to have my patients adequately taken care of [so I wasn’t] just pull[ing] up shop.”

Many of the retired or retiring physicians that were interviewed echoed the belief that finding a person to replace you in practice might be difficult but is of extreme importance, especially if you are in a solo practice, and they emphasized it might take time to find a replacement. The retirees believed that young physicians today have a different perspective on practice style and are not as interested in taking over a practice that requires 110 hours a week for patient care and running the practice. “I can think of three young physicians just a year or two out of residency whose goal is to confine their involvement in medicine to no more than 30, maybe 35 hours a week,” said one, “and [they can] accomplish that by working three 12-hour shifts at an urgent care center. They go home and forget medicine for the other 4 days of the week.”

Retirees had other things to say about finding a replacement. “I was in solo practice and took a partner in for the last two years,” said one interviewee. “It was obvious that she could not run the practice alone. I had to wait until we found another partner before I could leave. I think some of the younger doctors are not prepared for the demands on their private life that we put up with.” Said another, “I was in a primary care group and gave them a-year-and-a-half notice about retirement; in that time we were able to recruit a really good woman physician to take over the practice so it was pretty painless.” “I was in a group with two other women and I gave them six months notice,” said a retiree. “Someone joined shortly after I left and that worked.” A last physician said she had given two years notice in her group. “They got somebody and I actually cut back and worked half time and overlapped with this other person and that worked very well for the period of time that I was kind of unwinding myself from all this entanglement, and finally I left and she took over.”

Steps to a Successful Transition

In 1997 the American Medical Association (AMA) published a book titled *Closing Your Practice, Seven Steps to a Successful Transition* (2). The book includes helpful examples of patient notification letters, medical record transfer authorizations, and an extensive suggested reading list. (Instructions for locating this book from the AMA publications catalog are provided in our reading list at the end of this chapter.)

The steps for closing a practice that are offered this publication are useful and worthy of discussion here. Steps 4 and 5 from the book are combined into Step 5 (below), and Step 7 (below) includes suggestions gathered from other sources.

Step One: Notifying your employees and discharging employer obligations

This is probably the first step you should take after you decide to close your practice. Your employees need time to adjust to your retirement and formulate their own plans. The AMA book suggests that 3 months is a reasonable advance time to provide employees. You may need to give some employees an incentive to stay with you until the end to help you with the last-minute details.

Employees will have different reactions to your leaving. Some may become angry due to their own fears of finding another job. Others will be happy for you and begin to plan for a celebration. Try not to personalize your employees' reactions. Be ready to respond to their concerns and questions. If they are part of a retirement plan, contact the plan administrator and let your employees know what their options are. Tell them you will be writing to your colleagues inquiring about employment possibilities. Talk with local pharmaceutical representatives and hospital administrators to find out about what might be available for your employees. Although you are in the midst of planning for your retirement, you cannot forget about those people who have been with you for years and helped you get to this stage in your life. Helping to accommodate their needs will also help increase their desire to help you close the practice in an orderly fashion. The AMA book suggests providing one week of severance pay for each year of employment.

Discuss all this with your attorney. Most states require that employers pay for unused benefits such as sick leave and vacation. It may help to have written agreements with all employees about compensation for unused benefits.

Step 2: Notifying patients

Give your active patients up to 3 months notice that you will be retiring. Whether you are a physician in a group or solo practice, you need to give official notice that you are terminating the (legal) physician-patient relationship. Changing to new physicians is a significant event in most patients' lives, and considering their desires and those of their families and other caregivers, will ensure that legal, ethical, and emotional needs are met.

Defining what constitutes an "active patient" may be difficult. Seek advice from your local medical society or state medical board or both. The AMA book suggests that an active patient is any person seen in the last 2 years as well as those with any chronic or serious illness. For instance, you may have diagnosed a malignancy in a patient and thus he or she has not been seen by you for some time because multiple consultants have been providing care. However, the patient may still consider you the primary physician. For your patients who are in the middle of a crisis or critical stage of treatment, you may need to notify them differently. First, have a plan for transfer of care and meet with these patients to inform them and personally reassure them that they will receive excellent care. Follow this up with a letter that is more extensive than your standard letter. This letter should include what you discussed at your face-to-face meeting as well as the standard information.

Standard or essential information in each letter should include:

1. Date of practice closing;
2. Where the records will be stored, how to access them, and the deadline for submitting record requests;
3. Need for written authorization for transfer of medical records (include a copy of the authorization form in the letter);
4. Sources for emergency care;
5. Information on how to locate a new physician (which may require authorization from a managed care company); and, finally,
6. An acknowledgment and “thank you” to the patient for trusting you with their care. Wish them well and let them know something about your retirement.

Step 3: Medical records retention and disposition

Medical records can potentially become a big headache for retiring physicians. The more you know and the better prepared you are, the easier this aspect of closing a medical practice will be. Patients need to know where their records are stored and how they can obtain them. Even if you give patients copies of records when you cease practicing, you must safely store the originals for a period of time. This amount of time is designated by state law. If you have not sold your practice or transferred those records to someone else, you will still be responsible. Some physicians will ask a hospital to be the custodian of the records; some hospitals will agree to do this, or group practices that are interested in attracting your patients may accept responsibility for your patients. They may not want to pay you for them but they will at least be responsible for the records and provide them to patients if requested.

One of the retirees that we interviewed told the following story about medical records retention: “I sold my practice for a dollar. That dollar was important so I could get my medical records taken care of. In the buy and sell, I can show that the new physician is responsible for the records, not me. I did not check to see how legal this was but I felt comfortable with it because I saw other guys retire here and you couldn’t get their old records without a fight. They had them in the basement or in the garage or somewhere else and they were bothered for years about digging up an old record.”

Patients may require their medical records in the future for a variety of reasons including medical care, employment, insurance, litigation, and matriculation. The AMA policy on medical record retention and transfer stresses that when a physician retires, his or her patients should be notified and informed that they can authorize the physician's practice to send their records to a new physician of their choice. Records that are not transferred should be retained.

There are four key elements in dealing with medical records: retention, storage, accessibility, and costs (3).

Retention. The physician is bound by certain federal and state statutes during and after the practice's closure. You should contact your state health department, medical society, and licensing authorities to obtain their record transfer guidelines or recommendations. The appendix in this book includes an excellent discussion by the American Health Information Management Association on Protecting Patient Information after a Facility Closure. This document includes applicable state laws.

Medicare or Medicaid programs require record retention in their original or legally produced form for at least 5 years. If a patient has been provided education, training, treatment, or rehabilitation pertaining to alcohol and drug abuse, federal law requires a written authorization from the patient for these records to be transferred to another physician. To prevent errors, clearly mark this requirement on the front of applicable patients' charts.

If your state does not specify the length of time records must be kept, you need to be aware of and adhere to the state's malpractice statute of limitations for adults and minor patients. If the patient is a minor, records should be retained until the patient reaches the age of majority, as defined by state law, plus the period of the statute of limitations. Consult your attorney for more specifics on these issues.

Storage. If medical records are not being transferred to another physician, they may be archived with a reputable commercial storage firm. Some physicians rent space from another physician or store the records in their basement at home.

If the records are transferred to another physician or a commercial storage company, a written agreement should be executed outlining the terms and obligations. The agreement should include an understanding about confidentiality—specifically selling, sharing, discussing, transferring, or disclosing of any information to unauthorized parties; prompt return of information upon your request; and circumstances for destruction of any material. Your malpractice insurance carrier and attorney should be consulted regarding this agreement.

Recent discussions with some physicians indicate that the technology for scanning records into retrievable CD ROM disks has now advanced to where it is a less expensive and more reasonable option for records storage. As this technology is new it should be considered but with reasonable caution. Before choosing this option, discuss it with more than one company and talk to some of their prior customers. Have a few of your records scanned, and then retrieve and print them to see for yourself if this technology indeed does work.

Accessibility. No record should be released without a written request. When records are requested, only copies should be provided; retain the originals until the required retention period has expired.

Costs. There are expenses associated with medical records, namely the costs of labor to process them, copier equipment, storage boxes and supplies, and shipping. Consider the cost associated with using a commercial firm versus the potential cost associated with accidental destruction or loss of records that could occur when storing them in your home or at another physician's office. This is a complex issue that needs to be well thought out before a final decision is made.

Other issues. If you have X-rays in your possession, check with the radiology department at your local hospital about how long they need to be kept. Mammograms need to be kept for up to 10 years. Microfilm and CDs can also be used to archive some materials. If you are going to destroy hard copy records, be sure that all information is shredded. Consult with your attorney and professional associations to help answer your questions on this topic.

The process. Once you have addressed the above issues, it is time to begin the process of notifying patients and disseminating records. This can be done in the following order (Table 2).

Table 2.—Tips for notifying patients and disseminating records.

Notify your malpractice insurance carrier to make sure that your coverage continues. To minimize the amount of storage space needed, purge records as appropriate.
Notify patients as suggested in Step 2. Use registered mail for patients with serious illness or other high-risk situations.
Place a copy of the notification in each patient's chart as well as any copies of patients' requests for records.
Notify by letter your referring physicians and other professional associates.
Finally, print announcements about the practice closure in the local newspapers. Keep copies of the announcements.

It seems reasonable to charge a nominal fee for making copies of medical records after a practice closes. If you had a policy in force governing this service before you closed the practice, maintain that same policy post-closure.

See the appendix for a more extensive description from the American Health Information Management Association about how to protect patient information after a facility's closure.

Step 4: Notifying associations, organizations, and agencies

You will need to notify multiple groups of your change in status—some as a courtesy and others as a matter of law.

Drug Enforcement Agency (DEA). If you want to be able to continue prescribing medication, it is a good idea to retain your DEA number as many pharmacies use this number to assure themselves of your status. Notify the DEA of any change of address.

State boards of medical examiners. Notify state boards of your status and any address changes. You may be eligible for a reduced fee or a free license if you will be doing volunteer work for which you receive no compensation. For example, Florida will grant you a special license at no cost that permits you to provide free care at locations specified by the state. If you are going to give up your license do not just allow it to lapse. Write to the board and let them know your intentions. It may be worthwhile to keep your license for a few years after retiring to be sure there is not a need to retain it. You will be surprised at how often you may still need to use it. Some examples of when you may still use your license are: when volunteering, to write prescriptions, and to identify yourself as a physician if medical care is needed in an emergency situation, such as when on an airplane or at roadside. At various times, airline personnel, policemen, and EMTs have asked me to show my license when responding to emergencies.

Professional Associations. All national, state, and local associations should be notified. You can request to be moved to a retired membership category that has a reduced fee. Be sure to discover what privileges the category includes. Take responsibility for proactively changing your membership so that you can still give and receive appropriate information regarding notifications of meetings and activities.

You will also notice a decrease in the number of “throw away journals” that you will now receive. This may be a blessing, but if you enjoyed reading a specific journal, write directly to that journal’s publication office ahead of time (probably 6-8 weeks) and request that they return your name to the distribution list. This does not always work but it is worth the try. You can also ask a colleague in practice who still receives that journal to save it for you.

Step 5: Managing accounts receivable and collecting from slow payers

Your past policies will be the major determinant of how effectively you can collect from delinquent or slow accounts receivable. You have trained your patients and they will respond now the way they did in the past. Your patients are not sympathetic with your needs; they will be thinking primarily of their own. Now is not a good time to change your policies. It will only create hard feelings if you begin to harass them for payment. Once you announce your retirement, your ability to collect debts will be reduced.

Continue to request payments and use collection agencies in the same manner you did in

the past. Discuss these matters with your accountant and attorney. Also, consult with a few of your colleagues who have retired and ask them how aggressive they were in collecting overdue accounts. You cannot withhold a patient's medical record because he or she owes you money. You may place the patient in jeopardy by withholding records, and this may increase your financial risk.

For many physicians, insurance company payments comprise the majority of their accounts. These accounts should be pursued vigorously. Do not let a large amount of time lapse before following up on past due accounts. Your accountant and attorney can help with the more stubborn companies.

Step 6: Coordination with managed care and other insurance companies.

Read all the agreements that you have made with these companies. The agreements will usually tell you how to handle terminating your relationship with them. Consider giving your business manager a financial incentive to ensure that these accounts are managed appropriately.

Step 7: Handling all other details

All the other little details of closing a practice can be overwhelming, so develop a checklist to help you move through the tasks one by one. Procrastinating will impede the flow from work to retirement. The AMA book contains a helpful checklist that includes a column of when and what to do within each category. A few items on the checklist are: notify all suppliers and request final statements; complete all accounts payable; cancel magazine subscriptions; submit a change of address notification at the post office; dispose of all drugs; and notify workers compensation, unemployment insurance and other office liability policies. Your office manager, accountant, and attorney will do most of this. But if these tasks are not done, you are the one who will be held responsible for ongoing costs and liabilities. Do what you need to do to ensure that this is being handled appropriately and efficiently.

Separating from your practice

Closing one's medical practice can be stressful for the physician, staff, and patients. Each physician has a different separation experience. Most physicians are probably unable to share thoroughly about what it meant for them to practice medicine, how separating from their practice affected them, and how they are handling their feelings post-retirement. "I found it was difficult to actually help the patients make the transition," said one retiree. "The patients would find out from the receptionist which days I was going to be in and try to make their appointments when I was there. They did not want to see the physician who was taking my place." Many interviewees said they missed the daily contact with patients, and, as one physician put it, "the vicarious participation in families that we've all had for so many years." Many of our retired physicians communicated that it was difficult for their patients. "We had tearful hugging at the end and I found it to be really devastating," said one. "I felt I was sort of walking

out on people.” “I still live in the same place that I practiced,” said another, “and I run into patients who say ‘Dr. So and So is fine, but I miss you and I wish you were there. You were the only one that ever understood.’ I know I should take it as a compliment, but it’s really very hard.”

The following well-written story by family physician Barry Bub described the meaning he attributed to his practice and relationships, and the ritual he used for separating from them. His story, published in 2001 in *Medical Economics* (1), is reprinted here with permission.

“Joan, come in, we’re waiting for you.” This was the third time I had called my longtime employee (I’m not using real names) to join us so we could begin our closing ritual. She *knew* there was no need to be scurrying around the office emptying trashcans: We were not coming back after today. Then it struck me, and I felt a wave of empathy as I realized this was hard for her, too. I wasn’t the only one struggling to keep my emotions in check.

It was 5 pm I had seen the last patient of the day--and possibly, my career. I felt emotionally drained. I’d spent the last month explaining to patients why I needed to leave my practice after 25 years. And now I was about to say goodbye to this part of my life.

The exam room where we waited for Joan was just the way I liked it. Long ago, I’d stripped the walls of their dismal charts depicting an unhealthy gut or semi closed coronary arteries. I’d replaced them with poster-size photographs of colorful landscapes taken on my travels. The desk, which I like to keep in my exam rooms, was bare, except for pictures of my family and figurines from exotic locales. A vase with flowers sat on a side table. Classical music filled the room. I had intentionally created an environment that would calm patients.

Today, perhaps, it would calm us, too. Joining me in addition to Joan were another long-term employee; an elderly couple I had invited to represent my 2,000 or so active patients; and three former employees, I wanted us to bring closure to all the years we’d spent working, playing, laughing, and even crying in this special place.

It had taken me a long time to build a team of well-trained, motivated people who could work well together. We liked and respected one another and loved the patients. And the patients were good to us, stopping in sometimes just to bring goodies. I started my practice in 1973 and built it into something I considered high quality, high-volume, and well organized. With my staff’s help, I rarely worked more than 32 hours a week, including lunch breaks. Still, I was able to generate an income well above average.

The patients I saw in that time surprised me with an outpouring of empathy. They were genuinely sad. One patient asked me who would care for the flowers in the office's perennial garden. Another, acknowledging other personal touches I'd made, wanted to know whether the next doctor would have "little wood-carved cats on the windowsill." One elderly man burst into tears and gave me a bear hug, which surprised me because I had only helped him achieve minimal improvements in his arthritis. He then asked to buy one of my photographs. I gave it to him.

In a minigroup Gestalt session, I talked about the healthiest way to leave. It became obvious to me that I had incorporated a great deal of spirituality into my practice. The Gestalt techniques I used with patients, my relationship with my staff, and even the office decor helped create a sacred "safe" space where patients could bring all of their troubles, emotional as well as physical. Besides, my staff and I had grown up in that building. Clearly, a ritual to deconsecrate the office would help us create closure.

But what kind of ritual? I briefly considered holding an open house for former and current patients. My attorney advised against that. That was okay, because I knew I needed something more intimate. That's when I settled on a closing circle.

As it began, after Joan finally joined us, I welcomed everyone and read a brief vignette about a recent patient interaction that meant a lot to me. The patient had confessed to me that she never followed my health advice, because she was so anxious about her chronically ill husband. I'd helped her understand the connection between her self-neglect and her life-long fear of abandonment. Then we'd addressed her feelings about my leaving. After recounting that experience, I thanked all the people present for their loyalty and friendship. I asked each of them to share her feelings about the time she'd spent here, and for a single quote summarizing her experience and what she'd take away with her.

With teary eyes, Terry told of difficulties between us. (Because of her insubordination, I'd arranged for another practice to hire her.) She talked about what it meant when I later visited her in the hospital after her automobile accident. Subsequently, she returned to my office and became a model employee.

Joan remembered feeling frightened at her initial interview. "I learned to value myself," she said. Liz said she accomplished her dreams. (She had been cleaning houses when I hired her, and has since become a very capable nurse's assistant.) The tissue box circulated as people spoke. Anna, our elderly patient, handed out gifts to all of us. Her husband John, who has Alzheimer's, just smiled.

We ended with a blessing and a hug. I took down the photographs and gave them and the little carvings away as mementos. We removed the sign from the front. Then we completed our closing ritual with a meal at an area restaurant, where we celebrated the bonds we'd built over the years.

As we said goodbye after our meal, I felt privileged and complete. The transition ritual had been healing, and I knew it would help me survive.”

This powerful story has many messages. No doubt readers can picture their own office and what it has meant to them, and their staff and how they struggled and rejoiced together over the years of providing quality care. The one thing that struck me the most when I read this was the *need for a ritual that deconsecrates the office in order to help create closure for all those involved*. Perhaps the ritual is essential to one's ability to say goodbye to this phase of life and move on to the next. Perhaps some of the difficulties that physicians experience when they close their practices are rooted in their not having created a ritual.

References

1. Bub B. Saying goodbye to the practice I loved. *Medical Economics*. 2001;(Jun. 18): _____.
2. American Medical Association. *Closing Your Practice, Seven Steps to Successful Transition*. Chicago : _ 1997. 3. Schechter KS. Practice Pointers: Practice closing? Remember to transfer patient records. *AMNews*. Jan. 22, 2001. http://www.ama-assn.org/sci-pubs/amnews/pick_01/bica0122.htm

Suggested Reading List

1. American Medical Association. *Closing Your Practice, Seven Steps to Successful Transition*. Chicago

To purchase this book from the AMA, call (800) AMA-3211 (for members); (312) 464-5000 (for nonmembers); or (800)621-8335 to order publications. You may also look at the AMA Web site (www.ama-assn.org). Click on the Site Map, go to Products and Services, click on the AMA Press catalog, and then click Practice Management and Career Development. Next, click on **Practice Management**. Scroll down to locate the book. The direct URL is https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod170092

2. Sutherland PH. *Twelve Steps to a Carefree Retirement: How to Avoid Pre-Retirement Anxiety Syndrome*. 1999.

To purchase this book from the AMA, follow the instructions in the paragraph above.

You can locate it listed at via the AMA Press catalog, by following the above instructions, but after selecting Practice Management and Career Development, click on **Career Development**. Scroll down to locate the book. The direct URL is https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=OP208399%20

Chapter 7: Keys to Well Being

Man will know he is old:

When there are more and more little bottles in the medicine cabinet.

When year by year his feet seem farther from his hands.

When his bones ache.

When he decides not to drive at night anymore.

When, if you are wearing one brown and one black shoe, quite possibly there is a similar pair in the closet

Crowley (1)

Retirement can be very positive if it is planned and anticipated as the next stage in a fulfilling life. Financial, health, and relationship issues are some of the most important ones to consider in retirement. For most physicians, money concerns are more often a pre-retirement issue rather than a post-retirement one. Most physicians plan fairly well for their future finances, but not as well for their relationships and their physical and mental health. Their own health has usually taken a back seat to their patients' health concerns.

Dr Sam M, 66 years old, was retired for only two years when he discovered he had colon cancer. He always told his patients about fecal occult blood, sigmoidoscopy, and colonoscopy, but could never find time to have these exams himself. He had no time to deal with his anger at himself about not being screened because he now needed to deal with surgery and possibly chemotherapy and radiation therapy.

The negative aspects of aging may occupy many of our thoughts. Aging can be difficult, but the positives are numerous. Many of the restraints of youth are gone. You can still be creative, sexual, confident, curious, and altruistic. Aging allows you to discover your own special needs and develop other creative interests. We can enjoy a slower pace of life and a more enhanced sense of well-being. A positive attitude lowers levels of stress and anxiety, enhances our health, and makes family and friends want to be around us.

Life Stages

By the time you reach retirement age, you have gone through most of life's tasks. In early adulthood you developed values, a sense of self, and a personal identity. Following this you most likely achieved a committed relationship with another person. Next, you had a career and developed a professional identity. These three stages were more self-directed. The next stages are more directed toward family and others. Vaillant (2) refers to this change of direction or transition as the social maturation of the individual.

This maturation process involves accomplishing a series of life tasks. These life tasks begin in early adulthood with the stage Vaillant refers to as Identity. During this stage, we develop values, passion, and a sense of self that facilitates separation from our parents.

The next stage, Intimacy, involves establishing a reciprocal committed relationship with another person. The third stage is Career Consolidation. Here we establish an identity in the world of work. At this stage we are capable of providing ourselves with contentment and compensation from this work or job, and this stage requires competence and commitment.

The first three stages are self centered and direct toward the needs of the individual. The next three stages are less oriented towards self and more oriented toward others. This stage is generally accomplished later in life. However, individuals do not always enter into all these later stages, and the degree of achievement will vary widely.

The fourth stage is Generativity. This represents a commitment to care for, nurture, and guide the next generation. This provides a means of ensuring that your values, behaviors, and wisdom are not only passed on to your children, but your patients and all the other learners you wish to teach.

Dr Marc S, who retired from a busy urban family practice, felt fortunate to be able to take a yearly trip to Latin America to teach medical students. Once he retired, he was able to visit there 2 to 3 times a year. During many of his visits, former students would express their gratitude for the principles of patient care that he taught. Dr Marc S was being generative and also maintaining his self-esteem.

The next stage, Keeper of the Meaning, is one that is unique and not entered into by many. During this period physicians may become curators or historians for their medical organizations or state academies, their church, or other organizations that are important to them. In this stage of life, the preservation of culture and traditions is highly valued.

Dr Sue K was the first woman physician to graduate from her medical school. In her later years of practice and now during retirement, she developed a list of all female graduates, their addresses, and the major accomplishments they had each achieved. She updates the list yearly and includes in her writings suggestions on how to juggle the multiple responsibilities of physician, mom, and wife. She plans to write a book that describes some of the challenges of being a woman in a male-dominated system. Sue is keeping the meaning by preserving the history and traditions of women in medicine.

The last of life's great stages is Integrity, a challenging but necessary stage for all of us to master. It is the chance to balance the declining state of one's body while expanding the knowledge of life's meaning. It is a time of accepting one's self and one's life work. It signifies a relative peace of mind regarding death, and demonstrating that to one's loved ones. This stage also encompasses accepting physical and mental limitations but not letting these limitations dominate your life. Periodic bouts of fatigue, sorrow, and acute grief are all companions of aging. Many older retirees in our groups stressed the importance of not letting health problems or the death of friends or loved ones depress them to the point of inactivity.

Positive Attitude and Emotional Maturation

Dr Rose L had breast cancer, grieved the resultant disfigurement, and underwent chemotherapy treatment. She knows her prognosis and has shared that information with her family. She now says it is time to get on with her life. Rose has four trips planned in the US this year to sites she has never seen, during which time she will visit her grandchildren. She is considering taking one of the grandchildren with her on each trip.

Another physician, Dr John M, a vibrant 70-year-old, remarked sadly that the death of his beloved wife, Ellen, had devastated him, but he gradually decided to resume his daily activities. Eventually he began to experience a little joy in each day even without his beloved beside him. He now fills his time by regular visits to a nursing home to read to elderly patients, and he started a group for men who have lost their wives. He still thinks of Ellen every day, but he calls these thoughts “medicine for life.”

Without a positive attitude, some of life’s inevitable hardships can lead to depression, ill health, and premature death. Staying active, varying daily routines, and engaging in meaningful work can help keep depression and hopelessness at bay.

Physicians in early retirement also need to balance their rational thinking (which has served them well in their medical practice) with emotional maturation. Being emotionally mature requires maintaining a healthy balance between desire and reason. Doctors who have long had to repress emotions in order to deal with tough situations may now find themselves free to feel and express emotions in ways that they could not in the past.

Learning to express feelings and getting in touch with what you’re feeling is difficult, especially if you have learned you were not supposed to have feelings or you kept your emotions repressed in order to let others feel. Growing older successfully is also dependent upon your ability to adjust to the changing needs and values of family, friends, and society. Dr George S, newly retired and still not quite settled into this new phase of his life, finds himself angry on a daily basis. He’s not quite sure why this is so and does not know how to deal with his anger. He yells at his wife for the way she does his laundry and the meals that she cooks; but she been doing the laundry the same way during their entire marriage and George used to love her meatloaf. Consequently, she’s often upset and finds herself crying easily.

Dr and Mrs S have some work to do around handling their feelings and communicating their needs and desires. They will need to change the family dynamic now that Dr S is retired and is beginning to adjust to a new routine without the schedule, pace, and high esteem he had as a successful practicing physician. Being critical of his wife’s cooking and how she does the laundry has been the target for his anger. He will need to look for appropriate outlets for his anger. Mrs. S will have to adjust to a husband who spends a lot more time at home. They could begin to focus on valuing their time together and planning to do things together, such as traveling and playing golf or tennis. Also, Dr S may now get to know his grandchildren and spend time with them in a way he was not able to do with his own children.

Emotional well-being in later years requires learning new coping methods and healthy outlets for your feelings—for love and caring as well as anger, fear, and sadness. Retirement is still a time of learning. Those doctors who are flexible and willing to try new ways of thinking and feeling will have an easier time in later years than those who are more rigid and inflexible. Life is a process of continued growth even in old age.

Physical and Mental Ability

Dr Joan H cited her changing physical health to be one of her major concerns as she aged. She was nearing retirement age and although she had been athletic in her youth, the demands of private practice and a family left her little time for exercise. She had gained some weight over the years, had high blood pressure, and her cholesterol levels were elevated. Joan had advised her patients about these risk factors throughout her career, but she rarely took time to consider her own health. She also knew that a sedentary lifestyle is equal to smoking 20 cigarettes a day; although she did not smoke, her inactivity was putting her at risk. Walking 30-40 minutes a day, along with medication for her blood pressure and high cholesterol, would help tremendously to improve Dr H's health. Walking for 30-40 minutes a day for 5-6 days a week has been associated with a decreased incidence of diabetes, hypertension, cancer, anxiety, and depression. Joan had psychological difficulty following the suggestions of her physician, who happened to be 15 years younger than she, but eventually she was able to begin an exercise program and reduce many of her risk factors.

Dr George M would also benefit from a walking program. In his middle 60s and planning to retire soon, he had suffered from mild depression for most of his adult life. Teaching at a medical school and running a private practice, however, had kept him occupied and his depression at bay. Now, anticipating his coming retirement, Dr M was feeling increasingly depressed. His greatest fear was that once he fully retired, his depression would become major and he would not know how to manage it. After discussion with his family physician, Dr M was placed on medication, an appointment was scheduled with a psychologist, and he responded well to this treatment.

One of the ailments that retired women physicians most worry about is osteoporosis. Dr Gail O had a bone density test at age 62 and discovered the beginnings of osteoporosis. She increased her intake of calcium and began to do resistance exercises with 5- to 10-pound hand weights. This has improved her balance and hopefully will increase her bone density. It has been shown that exercise in postmenopausal women delays fracture risk by 36% and the risk of falls by 25%. (3)

There are other physiologic changes that occur in older sedentary adults: a 10% decrease in aerobic capacity per decade, a decrease in pulmonary function and maximum cardiac output, and reduced muscle mass and muscular strength. Also, a decrease in bone mass and an increase in body fat generally occur. Gail O had many of these problems. Hopefully, by beginning to exercise she would help reduce the impact of these physiologic changes. It's also important to note that going to a gym was *not needed* for

Dr O to increase her physical strength and bone density. Small weights, walking or swimming, riding a bike, gardening, tennis, golf, dancing or any activity that causes the heart rate to go up and produce a sweat on the brow are examples of exercises that can be done at home or in a local park or golf course. Vigorous exercise is not needed or recommended. Also, certain people with disabilities that keep them from doing weight-bearing exercise can do their routines in a swimming pool or hot tub. They can also do chair exercises. These are especially good for elderly adults: the person sits in a chair and moves her or his arms and legs in a rhythmic fashion. Gail saw that this technique worked for her elderly mother. She and Gail would exercise three times a week to music and found it to be not only health-promoting, but a way to have fun and connect with each other. Exercising with a relative or friend has additional psychological benefits. Stretching exercises and yoga are other ways to give muscles the boost they need and to have fun in the process.

Facing Challenges: A Story of Adaptation

After the death of his wife, Dr Mike A suffered tremendous grief and some guilt. The couple had planned a retirement of traveling to visit friends and their grown children. When Mary died unexpectedly, Mike was inconsolable. After several months, he knew that he had to make a decision to take control of his life or he would drown in despair. He went to the pound and picked out a mongrel dog, which he named Daisy, and he felt better instantly with another living thing to care for. He volunteered to become a grandpa who reads to the sick children in the hospital, thus letting him care for patients in a different way and still be around the hospital. He also went to visit his son's family and began to see his old friends again. Doing all of this gave Mike a sense of usefulness, a way to adapt to a major life loss, and a sense of personal control in adjusting to what felt like an out-of-control situation—the unexpected death of a spouse.

Mike A had been retired for about five years when he began to notice that he would misplace things and forget to feed the dog. He began to take time to put things such as his car keys and checkbook in the same place. He found that he could easily remember where they were if he did this consistently. Daisy let him know that she was not too happy after a few missed meals. He made a weekly checklist, which he attached to the refrigerator, to remind him to feed Daisy on time.

Decrease in short-term memory is one of the biggest changes people face in aging. However, long-term memory changes very little. Older people like Mike can adjust and compensate for these changes. Mike began to do the daily crossword puzzle in the newspaper and played computer games with his grandson when the youngster visited him. Adaptation is one key to help people deal with the effects of aging on their physical and mental abilities.

Loss of memory and Alzheimer's disease is a very real fear for older people. In spite of all the myths about changes in mental abilities of older adults, intelligence tests show minimal change with aging. There is some slowing of how one perceives sensory stimuli, and the ability to recall and register information may decrease. (3) However, the ability to manage daily affairs actually increases and learning capacity continues throughout life. People may have problems in processing information due to their diminished hearing and sight, but, in general, not resulting from any loss of brain function.

The old cliché of whether one considers the glass to be half empty or half full applies just as much to the way retirees look at life as it does to the perspectives of younger optimists and pessimists. However, in later years, a positive attitude can truly be an asset as one's health and mobility decline. The Harvard Study of Adult Development (2) found that objective good physical health was less important to successful aging than subjective good health. Many ill people didn't perceive themselves as sick. They knew that they had an illness, but chose to get on with life. As Dr Joan H, "I refuse to get preoccupied

with my health problems so that I cannot do the things that I enjoy. I will take care of my hypertension and cholesterol, exercise, and not worry needlessly.”

For some older adults, things are not that easy because they have serious illnesses, major losses, and disabilities. However, most people can still develop a positive attitude if they understand how much their attitude helps with their daily lives. The difference between happy and not-so-happy retirees is attitude, resolve, and emotional maturity. Happy retirees respect their own opinions, are flexible and adaptable, take on new challenges, and learn new things. They don't hold on to the suffering that comes with pain and losses, and they do not accept as true society's myths about older folks. Dr Helen S ran in her first marathon at the age of 56 and enjoys a rich sexual life. Dr Richard M always wanted to learn a foreign language and after his retirement, he enrolled in the local community college to study Spanish.

Life satisfaction scores do not usually decline in the elderly except in the old old. Most people adapt to the losses associated with aging. Older individuals report less stress, better coping ability, and lower expectations. (4) Having lived a long time helps one develop strategies to handle most of life's trials.

A sense of personal control is critical to a feeling of well-being. The inability to control one's environment leads to feelings of helplessness, sadness, and eventually, depression. Disability or a significant illness may lead to a perceived loss of control or independence. (5) Also, feeling unable to control one's environment has been associated with physician career burnout. (6) Professional counselors suggest ways to treat and prevent burnout in retirement. These include: spending time with family and friends, religious or spiritual activity, a supportive spouse/partner, a positive outlook in the face of negativity, and good self-care through nutrition and exercise. Many retirees who live alone experience feelings of loneliness and don't take the time to prepare good food for themselves. Many suffer from anxiety and long, lonely hours of doing nothing but watching television. Dr Barbara J found herself divorced and childless at age 62, no longer able to work. She had few friends or hobbies. She suffered anxiety attacks and spent most of her time in her small apartment. Her one saving grace was a church within walking distance. It was there that she began to make friends, attend the occasional church supper, and experienced a sense of belonging.

Recognizing and Preventing the Negative Consequences of Stress

For physicians who have counseled numerous patients on how to manage stress, retirement brings an opportunity to practice some of those stress-management techniques on themselves. Dr. T. H. Holmes of the University of Washington assigned numerical values to stressful situations. With considerable accuracy he was able to correlate the number of stress points a person accumulated in any two-year period with the degree of seriousness of the disorder that the person was likely to suffer due to stress overload. Retirement earns 45 points on this scale, and the death of a spouse earns 100. Moving to a new location adds 20 points and changing jobs adds 36. Therefore, if someone retires, moves to a new location and takes on a different line of work, they will exceed 100 points

on the stress scale. This could lead to a serious illness if the person is not aware of the part stress plays in illness.

Dr Bob K and his wife, Alice, had spent most of their lives in the city. Bob retired recently, sold his practice and the couple sold their house and moved to a rural neighborhood. Bob took a part time job in an urgent care center to have something to do, but urgent care medicine was new to him and he found himself constantly stressed. Alice, his wife, missed her children (who had stayed behind), and the friends with whom she had spent a lot of time. She began to have migraine headaches and recurrent cold sores on her mouth. When the headaches occurred, they kept her in bed most of the day, and she was embarrassed about the cold sores. Therefore, she really did not have any incentive to make friends. Bob was eating and drinking more, and feeling anxious and unsure of his medical skills, but afraid to stop working at the clinic. He was also worried about Alice. Bob and Alice may have to get some professional help before they can deal with these current major stresses and the symptoms of that stress.

Stress during the retirement years cannot be avoided any more than it can in other times of one's life. However, preparation and prevention can go a long way to help minimize it. By avoiding too many changes too rapidly, Dr and Mrs. K could have minimized the stress they were experiencing. Had they really thought thoroughly about living in a rural area, far away from family, and how it would feel to be practicing a different type of medicine? Sometimes a trial run for a few months can give you a good idea of what to expect in a new situation. Hopefully, a good counselor will give them some tips on stress prevention in the future and ways to deal with the present.

Relationships with Friends

With aging comes the inevitable loss of those close to us. It is important for retirees to remain socially active and meet new people. New friends may never replace the lost closeness previously shared with others, but replenishing one's support system helps prevent feelings of isolation. The more people that one interacts with daily, the more chances there are to form new bonds and increase the strength of one's network.

Cultivating and nurturing friendships is an important part of aging. Several retired physicians discussed the ways that they had maintained and developed friendships. Dr Steve H said: "I had one retired doctor [friend who] recently died. We were very close friends and I really miss him. I have another friend that I interned with and he is also retired. We hike once a week. We also have a retired doctors' luncheon once a week. I enjoy getting together with all the other 'old docs' and talking about medicine or just sports or the daily news. It really gives me something to look forward to." Dr Ned E thought his association with non-physicians when he was in the Army helped him become a better person. "I think that you should become a better-rounded individual by having non-medical friends along with your medical friends," he said. Dr E thinks that friendship is one of the keys to a long life and he believes that associating with non-medical friends in retirement contributes to shared activities, learning new things, and having fun.

Since friends are such a valuable support system, it's important for retired physicians and their spouses to work on making and maintaining friendships, especially if they have been too busy in their careers to develop significant relationships outside their families. Spouses provide significant companionship but they cannot fulfill all their partner's needs. Christina and Sam were both retired physicians who enjoyed playing bridge with friends once a week. Christina also played with her women friends twice a week during the day, leaving Sam to feel left out and that Christina was being unfair. Unfortunately, since they had both been busy doctors, Sam had relied on Christina to take care of all their social needs and most of their friends were hers. Now's the time for Sam to reach out and make some new friends who enjoy some of the things that he does. The longer one lives, the greater the need to make new friends to give one's life more richness and ways to enjoy the remaining hours and days.

The Keys to a Rewarding Retirement

There are four basic activities that make retirement rewarding (2):

1. **Develop another social network.** It's important to be with people who make us feel good about ourselves. One example would be spending time with grandchildren or other young people. They are usually a source of pride and also a reminder that a part of us can go on after our death. Dr Pete S had been a college basketball player and he found joy in seeing his young granddaughter play basketball for the YWCA. Dr Sara H found pride and fulfillment in working for local environmental groups. She learned from others in the group and was appreciated for her knowledge of environmental issues. Dr Joe B loved to build things. He joined a group that built houses for the disadvantaged. The group was composed of individuals from all walks of life and this group provided a good outlet for his need to build and to do so with others.
2. **Rediscover how to play.** Activities such as golf, tennis, bowling, etc., not only provide opportunities for exercise and engagement with others but also renew the magic of childhood when most of us could express ourselves freely in play. Physicians usually have long denied within themselves their need for fun. They have viewed life as much too serious. Learning how to play once again will be difficult for some but rewarding for those who succeed. Dr Mary P loved playing house and dolls with her 5-year-old granddaughter Suzie. Mary and her husband also have taken up horseback riding and love the opportunity to ride all day long. For those of you who need a good dose of playfulness, try rolling around on the floor with a grandchild or a pet. You do not know what you are missing.
3. **Engage in creative activity.** Raising a family, caring for patients, and being a responsible member of the community has usually left little time for physicians to be creative. A good question for a retired physician to ask himself/herself is what healthy passion did you have to suppress in order to become a physician or raise a family? Is it a desire to paint, play a musical instrument, or write a book? Dr Joan

S had dreams of acting when she was a young girl however; her physician father wanted her to go to medical school. Although Joan was happy in her medical career, she still occasionally harbored fantasies of being on the stage. Now that she is retired, she has joined the local actor's group and performs regularly.

4. **Be a life-long learner.** Even as your body is aging, remember that being curious about the world and its peoples is one way to remain young at heart. Learning new things every day helps one keep involved in life and its ongoing processes. Some retired doctors choose to go back to school to get another degree or learn a new language. Some take non-credit courses at a local community college. Dr Maria L was happy to get the chance to read the many non-medical books that she had in her library and had never had the time to read. Dr Scott M teaches a physiology course at the local community college; he loves it because he learns about physiology as well as the values and thinking of young people.

What are the keys to well being? The most important issue is to remember that there are many positives to aging. A few of those positives are listed below:

- Creativity does not diminish with age.
- The ability to cope increases and stress levels decrease.
- Sexuality is more relaxed and a great majority of retirees are still sexually active.
- One has a better perspective about life and its rewards and pitfalls.
- By the time one becomes older, the capacity to love increases, and spouse and family become extremely important.
- Curiosity and altruism increase, and one has a clearer ability on ways to satisfy one's self.
- Levels of anxiety diminish for most retirees, gratitude deepens, and a sense of joy and humor prevail.

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Appendix A: Family Physician Retirement Survey (Abbreviated)

The AAFP sent this survey to 2,000 randomized AAFP members over the age of 50. This is the breakdown analysis of the 831 who responded to the questionnaire.

Gender: Male **89.7%** Female **10.3%**

Age: Under 50 **0.3%**
 50-59 **43.6%**
 60-69 **18.1%**
 70-79 **28.1%**
 80+ **9.9%**

Aggregate findings:

1. Are you now fully or partially retired? Yes 43.0% No 57.0%

If yes, at what age did you retire?

Under 50	0.6%
50-59	10.5%
60-69	50.0%
70-79	35.8%
80+	3.1%

Was it: Full retirement **66.4%** Partial retirement **33.6%**

2. If not retired, at what age are you considering retirement?

50-59	12.6%
60-69	61.6%
70-79	21.5%
80+	4.3%

Will it be: Full retirement **39.8%** Partial retirement **60.2%**

3. What are your major concerns about retirement? (Please check three that are most important.)

54.9% Won't have enough money	12.4% Will not know how to spend my time
30.0% Will become bored	10.2% Relationship with my spouse
30.0% My health	15.3% Future care of my patients
22.7% My patients don't want me to retire	5.3% Don't have other interests
23.7% No longer making a contribution to society	13.8% Other, please specify:
29.2% Keeping up with medicine	

4. What were your major reasons for retiring or considering retirement? (Please check three that are most important.)

22.5% Burned out	17.2% My health
28.4% Spend more time with my family	34.5% Managed care frustrations
37.9% Government impact on medicine	21.9% Practice management issues
9.3% Time to read	35.1% Time to travel
38.0% Want to pursue other interests	17.1% Other, please specify:

Question 5: What products or services could the AAFP provide that would be of value to you as you make this transition? Summary of responses.

Placement service: part-time jobs, volunteer opportunities, locum tenens	71
Money management advice (reliable, unbiased)	62
Already retired/nothing	44
Products (health/life/long term care insurance, drug coverage, malpractice coverage, well-managed retirement fund)	40
Continue providing journals, meeting notices	32
Articles in <i>AFP</i> regarding retiree issues	23
Seminars on retirement planning	20
Ways to prepare oneself for retirement	17
Reduce hassles (insurance/government/HMOs)	16
Continue CME programs	15
Advice from/experiences of retired FPs	15
AAFP retired division/retired FP organization/links to those who have retired	13
Discounts (membership dues, CME, meeting fees, etc.)	11
CME programs (retirement issues/estate planning)	9
Advice on closing/selling practice	9
Change legislation so physicians can work part-time or volunteer (cost of malpractice insurance):	9
Encourage young physicians to plan early	6
Help in finding a successor	5
Send money	4

Make available a practice management model/info to help physicians with business issues	4
How to leave patients/transition to new doctor	3
Annual or quarterly publication for retired FPs	3
Recommend lawyers/develop programs to help deal with contract issues and reimbursement	3
Counseling services (financial planning, career changes)	2
Relocating/where to move	2
Organize group tours/activities; retirement communities for FPs	2
Legal aspects of keeping records	2
Review of long-term care insurance policies	2
Increased reimbursement	2
National initiative to create FP retirement fund	2
Make CME available on the Internet	1
Record of CME hours	1
Research/recommend good retirement software	1
Take my calls for the next 2 years	1
Set up corps of physicians to work in age appropriate styles of practice	1
Program to certify retired physicians for teaching	1
Referral list of specialists by region to satisfy health needs of retired doctors	1
Advice for competing against HMOs	1
Continue push for long-term care and prescription drug relief	1
Help to get tax breaks for home repair	1

Question 6: What advice would you give to physicians who are considering retirement? Summary of responses.

Plan before you retire (second career, hobbies, travel, etc.)	167
Develop a good financial plan and start saving early	159
Use medical talents (volunteer, work/teach part-time)	76
Don't retire (work as long as able/enjoyable)	54
Exercise; maintain your health	36
Retire gradually (partial retirement)	33
Consider what's best for <u>you</u>	31
Do it	28
Stay involved with medicine (journals, local meetings, CME courses)	25
Contribute time to activities outside of medicine	25
Enjoy family/friends	24
Retire as soon as financially able	22
Prepare mentally, spiritually	21
Relax, enjoy life	21
Retire while young and healthy	20
Keep your mind active (read, education courses)	14

Seek expert financial advice	12
Learn to live on budget	7
Do what's best for patients (if you can't keep up or offer highest quality care, retire)	6
Consider moving; spend time in that community before actually moving	5
Stay in touch with patients and colleagues	4
Prepare for status change	4
Stay out of your spouse's way	4
Retire quickly (full retirement)	4
Plan for health expenses	3
Diversify investments	2
Plan carefully for record storage, availability, etc. in compliance with laws	2
Bring in a partner your patients will like; have transition period	2
Be ready to feel guilty for awhile; try not to	2
Learn computers	2
Discuss retirement plans with family	2
Membership dues are harder to pay when you have little or no income	1
Don't put money away to pass down to your children	1
Stay out of stock market	1
Sell out to a larger clinic or hospital to get the best price	1
Incorporate if feasible	1
Have lawyer lottery insurance	1
Transition to administrative medicine	1
Maintain equanimity	1
Read the book "Halftime"	1
In most cases, insurance "tail" prevents doing anything medical after retirement	1
Stay single	1

Appendix B: Charitable Immunity Legislative Information

I. Introduction

Tens of thousands of physicians, dentists, and other health care providers volunteer their time and skills to provide primary and specialty care to patients who lack public or private health insurance and cannot afford their care. They volunteer their time in their private offices, free clinics, and through organized networks started by medical societies, health departments, hospitals, religious groups, and other community organizations.

One of the challenges to these volunteer efforts is addressing the concern of practitioners regarding the risk of malpractice liability. Either clinicians are reluctant to volunteer without adequate coverage or non-profit organizations operating on extremely limited budgets must purchase malpractice insurance, which is often incomplete or very expensive.¹

Policymakers across the country have attempted to address this barrier to volunteerism. While state laws have historically controlled liability issues in malpractice, the desire to prevent the fear of lawsuits from chilling volunteer charitable activities stimulated Congress to decide to legislate in this area. As summarized in the last section of this manual, the 1997 Congressional passage of the Volunteer Protection Act (VPA) resulted in the creation of some liability protection for all volunteers carrying out charitable duties throughout the United States.

In passing the federal legislation, Congress chose not to pre-empt states from affording additional protections, especially in this area of tort law where state laws have traditionally governed. Accordingly, it is important to review the current state laws affecting volunteer clinician liability in order to ascertain the extent of liability protection that is afforded in any particular jurisdiction. At present, as well as prior to enactment of the VPA, most states have chosen to enact laws that provide some protections from malpractice liability for volunteer clinicians.² These measures are distinct from those covering emergency situations, where state laws (usually called “Good Samaritan” laws) have been enacted to encourage people—especially trained health care professionals—to offer assistance to people in need of emergent care.

This manual examines those state laws, in effect as of October 1, 2001, tied to the **non-emergent volunteer context**. In addition to a discussion of the various state approaches to “charitable immunity legislation” it includes a summary table describing key aspects of

¹ In this document, when we use the term clinician and describe state approaches, in all cases the term always includes physicians. In addition, depending on the specific laws of a state, other categories of licensed health care workers may also be included in the grant of limited immunity. We have also highlighted in the attached table the sixteen states that specifically reference dentists in their statutory efforts.

² A few states, such as Illinois, use a single piece of legislation to address the liability of clinicians volunteering in emergent and non-emergent contexts.

each state's legislation and a brief summary and description of federal legislation designed to provide protection from malpractice liability.

Please note that this manual does not constitute formal legal advice with respect to the current law of any particular state. In addition, it is important to keep in mind that new legislation or interpretive court decisions within a state can affect the status of the law. The best way to ensure that there has been no legislative or legal activity affecting a particular state law and/or to receive an interpretation of a specific piece of legislation is to seek legal advice from a knowledgeable attorney.

Volunteers in Health Care has on file legislation from all states with charitable immunity laws, current as of October 1, 2001. Generally the most up-to-date versions of state laws can be obtained via a paid search using a commercial database such as Loislaw, Westlaw or Lexis (although often expensive). The Internet provides access to free on-line texts of state laws, although the comprehensiveness of information may be inconsistent from jurisdiction to jurisdiction. (One useful site to find links to legislation in all 50 states is: www.prairienet.org/~scruffy/f.htm) Finally, local libraries often have copies of their state code, but there will be variability as to how often it is updated or whether it includes addenda for recent amendments. Community and law librarians often can provide information on how best to obtain copies of the current state law.

II. Overview of State Approaches

Examining the realm of charitable immunity legislation reveals the individuality of state legislative responses to the issue. Although there is a set of basic elements that can be used as a framework for discussion, no state legislation looks exactly like any other state's. Some legislation is captured in a few sentences, while others use several paragraphs to describe the law. In some instances legislative language is transparent in its intent, in others it is more difficult to interpret.

There are, however, a few summary statements that can be made. As of October 1, 2001:

- 42 states and the District of Columbia have some sort of charitable immunity legislation;
- 8 states have none: Alaska, California, Massachusetts, Minnesota, Nebraska, New Mexico, New York and Vermont;
- 37 states and the District of Columbia have legislation which creates some sort of limit on liability by specifically referencing volunteer health care providers, while the 5 other jurisdictions that offer some protection, do so by making reference only to volunteers generally;
- 16 states have legislation that makes specific reference to dentists or dental care;
- 12 states specifically reference retired physicians in their charitable immunity statutes; two--West Virginia and

Washington--have legislation in this area only for retired physician volunteers.

Most states choose one of the following routes in providing charitable immunity: 1) **changing the negligence standard of care** (that is, raising the standard from simple negligence to gross negligence) or 2) **indemnifying the volunteer provider** as if s/he were a governmental employee (that is, extending the liability protections state public employees routinely receive to the volunteer provider). (See Sections IV and V below.) A few states combine aspects of both approaches within their state laws.

In addition, practically all states that have charitable immunity legislation have qualifying conditions that affect coverage. These conditions are usually one of the following:

- restrictions on the setting in which the health care can be delivered;
- restrictions on the type of care provided;
- requirement of patient notification of liability limitations.

Some states also place limits on the amount that can be recovered by a patient through a lawsuit.

Several states have legislation that is not easily categorized. In Hawaii, for example, individuals are immune from liability if they provide volunteer care under the auspices of a nonprofit or governmental organization that has total assets under \$50,000 or that carries malpractice insurance of at least \$200,000 per occurrence (in which case the injured party can sue the volunteer clinician's sponsoring organization). In Delaware and North Carolina, if neither the free clinic nor the volunteer clinician carries malpractice insurance covering care at the clinic, a suit may go forward only in cases of gross negligence.

One must remember, however, that no matter what the statute, charitable immunity legislation is not guaranteed protection from litigation or assurance of early dismissal of a lawsuit. It does not mean that a patient cannot sue a volunteer clinician. What it can do—and this is not insignificant—is set the “bar” for winning a malpractice case high enough so as to make it more unlikely that a lawyer would advise his/her client to pursue malpractice litigation against a clinician.

It is also important to remember that the non-profit organization for which the clinician is volunteering may be not be protected by state law. Whether the sponsoring organization, its staff and/or board of directors is covered by legislation is a distinct issue from the question of volunteer clinician liability. While some states have attempted to protect both clinicians and their sponsoring organizations/administrators, others have legislated only to protect the volunteer clinicians. A discussion of this issue is beyond the scope of this manual and the information that follows addresses charitable immunity legislation only as it relates to individual clinician volunteers.

Appendix C: American Health Information Management Association Practice Brief: Protecting Patient Information after a Facility Closure Practice Brief: Protecting Patient Information after a Facility Closure (Updated) American Health Information Management Association

Patients trust their healthcare providers to respect their privacy, maintain the confidentiality of their health information, and assure its availability for their continuing care. When healthcare facilities close or medical practices dissolve, providers must be concerned with the protection of health information.

Procedures for disposition of patient records¹ must take several factors into consideration, including:

- state laws regarding record retention and statutes of limitation
- state licensing standards
- Medicare requirements
- federal laws governing treatment for alcohol and drug abuse (if applicable)
- guidelines issued by professional organizations
- the needs and wishes of patients

In some states, a state archive or health department will store health records from closed facilities. Generally, state regulations recommend records be transferred to another healthcare provider. If a healthcare facility or medical practice is sold to another healthcare provider, patient records may be considered assets and included in the sale of the property. If a facility closes or a practice dissolves without a sale, records should be transferred to another healthcare provider that agrees to accept the responsibility. If this is not feasible, records may be archived with a reputable commercial storage firm. Before records are transferred to an archive or another provider, patients should be notified, if possible, and given an opportunity to obtain copies of their health information. This may be done by publishing a series of notices in the local newspaper.

Regardless of the archival method used, the provider must assure that the integrity and confidentiality of the patient health records will be maintained and that the records are accessible to the patient and other legitimate users.

Background

During the course of treatment, patients share private details of their lives with physicians and other healthcare providers. Patients trust their healthcare providers to respect their privacy, maintain the confidentiality of their health information, and assure its availability for their continuing care. Because of this trust, healthcare providers must be concerned with the protection of health information when facilities

close or medical practices dissolve.

Liability Issues

Generally, a healthcare provider remains liable for accidental or incidental disclosure of health information during or after a closure. Therefore, the provider must make appropriate plans to protect the integrity of the records and the confidentiality of the information they contain, while assuring access for continued patient care. State statutes addressing facility or practice closure should be followed. These are usually available from the state department of health. If state statutes are silent on how to proceed, the provider should consider several other factors, as outlined below.

Retention Issues

State Laws/Licensure Requirements

A provider is bound by applicable federal and state statutes after closure, as well as during its operation. Many state health departments and licensing authorities govern healthcare facility closures and may outline to whom records should be transferred. In some states a state archive or health department will store health records from closed facilities. More commonly, state regulations recommend records be transferred to another healthcare provider.

If records cannot be transferred to a state archive or state health department, the state's requirements for record retention for both adult and minor patients should be reviewed before a policy is formulated. (*Note: Many states require approval from the state department of health or licensing authority before any plan is implemented.*)

To minimize storage and/or transfer costs, the provider may wish to destroy records that are past the period of required retention. For example, if state law requires that records be retained for 10 years after the patient's last encounter, records that are more than 10 years old could be destroyed. If state law does not specify the length of time records must be kept, the provider must consider the state's malpractice statute of limitations for both adults and minors and assure that records are maintained for at least the period of time specified by the state's statutes of limitations. A longer retention period is prudent, since the statute may not begin to run until the potential plaintiff learns of the causal relation between an injury and the care received. If the patient was a minor, the provider should retain health information until the patient reaches the age of majority (as defined by state law) plus the period of the statute of limitations, unless otherwise provided by state law.

The provider should also contact its malpractice insurance carrier. Both the provider and the carrier must have access to patient records after the closure in the event a malpractice claim is filed.

Medicare Requirements

If the provider participates in the Medicare program, it must retain records in their original or legally reproduced form for at least five years to comply with the Medicare Conditions of Participation.

Federal Regulations re: Alcohol and Drug Abuse Treatment

If the provider has offered services pertaining to alcohol and/or drug abuse education, training, treatment, rehabilitation, or research, disposition of these records must meet requirements outlined by federal law.² When a program discontinues operations or is acquired by another program, this law requires the patient's written authorization for records to be transferred to the acquiring program or any other program named in the patient's authorization. If records are required by law to be kept for a specified period which does not expire until after the discontinuation or acquisition of the program and the patient has not authorized transfer of the records, these records must be sealed in envelopes or other containers and labeled as follows:

"Records of [insert name of program] required to be maintained pursuant to [insert citation to law or regulation requiring that records be kept] until a date not later than December 31, [insert appropriate year]."

Records marked and sealed as prescribed may be held by any lawful custodian, but the custodian must follow the procedures outlined by law for disclosure. If the patient does not authorize transfer of his records to another program, they may be destroyed after the required retention period.

Recommendations from Professional Organizations

Professional organizations should be contacted for guidelines or recommendations. Such professional organizations may include local or state:

- health information management associations
- hospital associations
- medical societies

Physicians who are closing their practices may wish to contact the American Medical Association and their state licensure board for guidance.

Legal Advice

Advice from legal counsel should be sought to determine the appropriate retention period, assure compliance with state laws and regulatory agencies, and help plan for an orderly closure or transfer.

Budgeting for a Closure

Regardless of which plan of action your facility institutes to deal with the patient records, resources will need to be allocated to carry out the plan. Some of the resources that need to be budgeted for include:

- labor
- copy equipment and supplies

- postage
- telephone
- utilities
- storage boxes and supplies
- transportation costs (to storage unit)
- storage and retrieval costs for required retention period

Recommendations

As soon as a healthcare provider anticipates a facility closure or dissolution of a medical practice, the provider should begin planning for proper disposition of patient health records. The primary objective should be to protect the confidentiality of the information contained in the records. The second objective is to assure future access by patients, future healthcare providers, and other legitimate users.

To assure accurate information for continuing care, all health information must be completed before the records are archived. This includes transcription of all dictated reports and interpretation of any diagnostic tests.

Before records are transferred to an archive or another provider, patients should be notified, if possible, and given an opportunity to obtain copies of their records. Letters may be sent to former patients, or announcements may be repeated in local newspapers and professional journals to notify patients and their physicians about the upcoming closure/practice dissolution and let them know how to access their information. Patients should be given a reasonable amount of time (at least one month unless a longer time period is required by state law) to request copies of their records.

Elements to consider including in the letter to the patient are as follows:

- the date the facility will close
- notification of where the records will be stored and how to access them
- a release of information form to be completed to receive a copy of their medical record
- notification that only written requests for copies of health information will be honored
- notification of any time limitations (submission deadlines) on the period of time during which requests will be accepted
- instructions on how to seek a new healthcare provider

The facility should retain a copy of the actual letter sent to patients, along with the mailing list, post office receipt, and all returned (undeliverable) envelopes.

If the records pertain to treatment for alcohol and/or drug abuse, specific federal regulations³ must be followed.

Closure/Dissolution with a Sale

If a healthcare facility or medical practice is sold to another healthcare provider, patient records may be considered assets and included in the sale of the property. As part of the agreement, the provider should retain the right to access the records and obtain copies, if needed, from the new owners. In addition, if the new owner considers a sale to a third party, the original provider should retain the right to reclaim the patient records.

If the facility or medical practice is sold to a non-healthcare entity, patient records should not be included in the assets available for purchase. The provider should make arrangements to either transfer the records to an archive or another provider who agrees to accept responsibility for maintaining them.

Closure/Dissolution without a Sale

If a facility closes or a practice dissolves without a sale, arrangements should be made with another healthcare provider where patients may seek future care, unless otherwise required by state law. That provider should agree to maintain the records, permit access by authorized persons, and destroy the records when applicable time periods have expired. Health information management professionals at the receiving facility should be familiar with record retention and destruction requirements and confidentiality concerns and have systems in place to allow patients and other legitimate users access to the information. Prior to transferring the records, a written agreement outlining terms and obligations should be executed. The original provider is responsible for assuring that records are stored safely for an appropriate length of time.

If transfer to another provider is not feasible, records may be archived with a reputable commercial storage firm. Such a firm should be considered only if it:

- has experience in handling confidential patient information
- guarantees the security and confidentiality of the records
- assures that patients and other legitimate requestors will have access to the information

If a storage firm is used, specific provisions should be negotiated and included in the written agreement. Such provisions include but are not limited to:

- agreement to keep all information confidential, disclosing only to authorized representatives of the provider or upon written authorization from the patient/legal representative
- prompt return of all embodiments of confidential information without retaining copies thereof upon the provider's request
- prohibition against selling, sharing, discussing, assigning, transferring, or otherwise disclosing

confidential information with any other individuals or business entities

- prohibition against use of confidential information for any purpose other than providing mutually agreed upon services
- agreement to protect information against theft, loss, unauthorized destruction, or other unauthorized access
- return or destruction of information at the end of the mutually agreed upon retention period
- assurance that providers, patients, and other legitimate users will have access to the information

Providers may consider giving original records directly to patients, but only copies should be given to patients unless the required retention period has expired. During the required retention period, the provider may need access to the original records for the provider's own business reasons.

Regardless of the archival method used, the provider must assure that the integrity and confidentiality of the patient health records will be maintained and that the records are accessible to the patient and other legitimate users.

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Note: This practice brief replaces an earlier practice brief published in the September 1996 Journal of AHIMA.

Notes

1. Patient records may include paper, microfilm, optical storage, or computer-based health information, diagnostic images (such as radiology films, nuclear medicine scans, and cineangiography films), fetal monitor recordings, videotaped operative procedures, and information stored on other media.
2. Code of Federal Regulations 42 CFR Ch. 1 (10-1-85). [42 CFR Part 2 Subpart B, Paragraph 2.19]
3. *Ibid.*

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Exhibit 1 -- States with Laws/Regulations/Guidelines Pertaining to Facility Closure

Note: State laws addressing facility closure continue to evolve. If your state is not listed, please check with your state licensing authority. State Summary of Law/Regulation Citation

State Summary of Law/Regulation Citation

Alabama

When a hospital ceases to operate, either voluntarily or by revocation of its license, the governing body (licensee) at or prior to such action shall develop a proposed plan for the disposition of its medical records. Such plan shall be submitted for review and approval to the Division of Licensure and Certification and shall contain provision for the proper storage, safeguarding and confidentiality, transfer, and/or disposal of patient medical records and x-ray files.

Rule 420-5-7.10 (1) Hospitals, Rule 420-5-5-.02 (7) (h) End Stage Renal Disease Treatment and Transplant Centers, 420-5-2-.02 (6) (h) Ambulatory Surgical Treatment Facilities, 420-5-1.02 (5) (f) Abortion and Reproductive Health Centers, 420-5-18-.06 (9) Sleep Disorders Facilities

Alaska

When a hospital ceases to operate, a plan approved by the Department of Health and Social Services will outline arrangements for the immediate preservation of its records. Healthcare providers of Medicaid recipients must notify the department. Instructions will be provided by the department as to the disposition of Medicaid records. Nursing homes that cease to operate must contact the department for direction on disposition of their admission and death records.

Alaska Statutes

18.20.085 (c)

7 AAC 43.030

7 AAC 12.040(I) (2)

Arizona

Facilities that cease to operate must submit to the Department of Health a plan for preservation of records in accordance with state regulations.

R9-10-221. R -- General Hospital

R9-10-321. R -- Rural General Hospitals

California

Within 48 hours of ceasing to operate, the facility must notify the Department of Health of its plan for the safe preservation of medical records. Should the facility change ownership, written documentation must be provided by both the old and new licensee outlining the arrangements made for transfer of medical record custody, safe preservation of the records, and access to the information by both the new and old licensees and other authorized individuals.

Title 22, section 70751 (d)

Title 22, section 70751 (e)

Colorado

When a facility closes, arrangements must be made for transfer of the medical records to a new custodian. A written memorandum of understanding or contract shall be signed by the new custodian outlining the date, location, and receipt of transfer. The written agreement will transfer responsibility for the retention and maintenance to the new custodian. If a willing custodian cannot be obtained, the facility must contact the local health department or other appropriate local government so temporary storage may be arranged. Public notice should be provided through the newspaper or general news release. Authorized parties should be given the opportunity to assume identified records.

Guidelines from Colorado Hospital Association, *Consent Manual and Guidelines for Release of Health Information*, 1996

Connecticut

A practitioner or agency should be aware of the specific requirements as to the existence and contents of the medical record and at least the legal requirement for retention of the record. The retention period applies even if the agency or individual ceases to operate.

Guideline from Connecticut Health Information Management Association

Florida

Facilities involved in an acquisition, merger, or closing should maintain records in accordance with state law. In a merger, the new facility should merge the old entity's active records with its records and prepare

a retention schedule for the inactive records. The merger agreement should include a provision detailing who is responsible for records. Florida General Records Schedule for Hospital Records requires facilities to submit a records destruction request, form LS5E107, and obtain permission from the licensing agency before proceeding with a record destruction. Florida Administrative Code requires a licensee to notify the department of impending closure 90 days before the closure. The facility must advise the licensing agency as to the disposition of medical records.

Florida Administrative Code 59A-3.153

Hawaii

Before a healthcare provider ceases operations, immediate arrangements approved by the Department of Health shall be made to ensure the retention and preservation of its patient records. In an acquisition or merger, the succeeding providers are liable for preservation of basic information from the medical records in accordance with state law.

Title 33, section 622-58 (e)

Idaho

Facilities should adhere to Idaho code and Idaho Practice Acts regarding maintenance and retention of patient information when a facility closes.

Idaho code 39-13941.C

IDAPA 16.03.0220304b

IDAPA 16.03.14360

Illinois

The licensee shall notify the Department of Public Health of the impending closure of the hospital at least 90 days prior to such closure. The hospital shall implement a policy for the preservation of patient medical records and medical staff credentialing files.

77 Illinois Administrative Code, Chapter I Section 250.120 (b), 250.1510 (e) (2), and 250.310 (a) (16)

Indiana

Upon closure, the facility must transfer the medical records (preferably in microfilmed format) to a local public health department or public hospital in the same geographic area. If the records cannot be transferred to a public health department or public hospital in the same geographic area, the records should be sent to the Board of Health.

Hospital Licensure Rules of the Indiana State Board of Health 410 IAC 15-1-9 (2)

Iowa

When a facility closes or transfers ownership, all active patients should be notified and given an opportunity to obtain copies of their records. In addition to individual notices to patients, a public notice is generally published in the newspaper of general circulation advising patients and physicians of the location of the facility's medical records and how access may be gained to them. The facility is liable for preserving the confidentiality and security of the records until ownership is assumed by another or the required retention period has expired.

Guidelines from Iowa Health Information Management Association's *Guide to Medical Record Laws*, 1993

Kansas

When a facility closes, it shall inform the state licensing agency of the location where the records will be

stored.

Kansas Regulations 28-34-9a (d) (1)

Kentucky

Should the facility discontinue operation as a result of disaster or for any other reason, the facility must provide a written plan for the storage of the medical records to the state licensing agency.

Kentucky Administrative Regulations 902 KAR 20:016 Section 3 (11) 3

Louisiana

The secretary of the Department of Health and Human Resources shall adopt rules, regulations, and minimum standards providing for the disposition of patients' medical records upon closure of a hospital. Such regulations may require submission by a hospital that is closing of a plan for disposition of patients' medical records to the secretary for approval.

Louisiana Health and Human Resources Administration Acts La, RS 40; 2109 E

Maryland

Should a physician practice expire, his/her representative must send a notice to the patient at the patient's last known address and publish a notice in the local newspaper, affording the patient an opportunity to obtain Medical copies of the medical record before the records are stored, transferred, or destroyed. Only home health agencies are required by state regulations to retain medical records after the agency closes.

Code of Maryland Regulations Subtitle 4. Personal Medical Records, 4 -- 403 Destruction of Records

Massachusetts

Should the ownership of a hospital, an institution for unwed mothers, or a clinic change, the new owner must maintain all medical records from the purchased facility. Should an institution permanently close, the institution will arrange for preservation of such medical records for the 30-year retention period. The facility/physician must also inform the state of the location and availability of these records.

Massachusetts Statutes 111, section 70

Minnesota

No specific statutes or regulations exist to address disposition of medical records at the time of a facility or practice closure. Statutes require hospitals to permanently retain those portions of medical records as defined by the Commissioner of Health. Physicians have a professional responsibility for the proper management of medical records, including disposition at the time of a practice closure.

Minnesota Statutes 145.30, 145.32, and 147.091 Minnesota Rule 4642.1000

Mississippi

When a facility closes, it must turn over its records to any other hospital or hospitals in the vicinity that is willing to accept and retain the medical records. If no facility is available or willing to accept the medical records, then they will be promptly delivered to the licensing agency.

Mississippi Code, section 41-9-79

Missouri

New operators of nursing, convalescent, and boarding homes are required to retain the original records of residents.

Section 198.052

Nebraska

When a hospital closes, all medical records will be transferred to the licensed facility to which the patient is transferred. All remaining records shall be disposed of.

Title 175, Chapter 9, 003.04A6

New Hampshire

Should an outpatient clinic, residential treatment and rehabilitation facility, or home health service cease operation, the safe preservation of the clinical records must be provided for.

Administrative Regulations He-P 806.10, He-P 807.07, and He-P 809.07

New Jersey

Before closing, the hospitals' governing authority must submit a plan for record storage and service to the Department of Health.

Section 8: Section 10 NCASC 34B-7.4 (b)

North Carolina

If a (facility) discontinues operation, its management shall make known to the division where its records are stored. Prior to destruction, public notice shall be made to permit former patients or their representatives to claim their own records.

T10: 03C. 3903 -- Hospitals

T10: 03H. 2402 -- Nursing Homes

North Dakota

North Dakota Hospital Licensing Rules require that if a hospital discontinues operation, it shall make known to the department where its records are stored. Records are to be stored in a facility offering retrieval services for at least 10 years after the closure date. Prior to destruction, public notice must be made to permit former patients or their representatives to claim their own records.

North Dakota Administrative Code, section 33-07-01.1-20 (1994)

Oklahoma

In the event of closure of a hospital, the hospital shall inform the Department of Health of the disposition of the records. Disposition shall be in a manner to protect the integrity of the information contained in the medical record. These records shall be retained and disposed of in a manner consistent with the statute of limitations.

Oklahoma Hospital Standards 310:667-19-14 (b) (4)

Oregon

Should a hospital or related institution change ownership, the medical records must be retained and become the responsibility of the new owner. Should a hospital close, the medical records may be turned over to any other hospital or hospitals in the vicinity willing to accept and keep them.

Oregon Administrative Rules 333-70-055(13) (14)

Pennsylvania

The Department of Health must be informed of the location of the stored records for the closed hospital. The storage facility chosen must provide retrieval services for five years after the closure. No records can be destroyed until after public notice, in the form of both legal notice and display advertisement, is placed in a newspaper of general circulation. Former patients or their representatives must be provided the opportunity to claim their records prior to destruction.

28 Pennsylvania Statutes, section 115.24

South Carolina

South Carolina Department of Health and Environmental Control regulations specify that hospitals and institutional general infirmaries must transfer ownership of all medical records to the new owners if the facility is sold. The facility will make arrangements for the preservation of the medical records after a closure. The department will be notified of the arrangements made to preserve the records.

Regulation 61-16 section 601.7D, Regulation 61-14 section 504.3, Regulation 61-17, Regulation 61-13

Tennessee

Should a hospital close, it must surrender the hospital records to the Department of Health and Environment. The facility must deliver the records to the department in good order and properly indexed.

Tennessee Code section 68-11-308

Texas

The licensing agency shall be notified by the closing facility of the identity of the record custodian and the location of the stored records. Should a special facility change ownership, the new owners must maintain proof of medical information required for the continued care of the residents.

Texas Hospital Licensing Standards 1-22.1.6 and 12-8.7.6

Utah

Within three business days of closure, the hospital must provide a written plan to the Department of Health outlining steps that will be taken to provide for the safe storage of all medical records and patient indexes for the 10-year retention period. Any plan submitted must include provisions for prompt retrieval of the stored records on demand. A public notice of the storage location and retrieval procedure must be placed in the local newspaper. The facility may choose to store the records with another hospital or transfer the records to the attending physicians provided that either party is still located within the community.

Rule 7.406 A and Rule 7.406 D

Virginia

Virginia has no regulations that address hospital closure, but nursing home closure is addressed in its Rules and Regulations for the Licensure of Nursing Homes. At closure the owners shall make provisions for the safeguarding of all medical records. Should the facility change ownership, provisions will be made for the orderly transfer of all medical records.

Rules and Regulations for the Licensure of Nursing Homes 24.7

Washington

When a hospital closes, it shall make arrangements for the preservation of its records in accordance with applicable state statutes and regulations. Any plan of action must first be approved by the Department of Social and Health Services. If a hospital changes ownership, the medical records, indexes, and analysis of hospital services are not to be removed from the facility and will be retained and preserved by the new owners in accordance with applicable state statutes and regulations.

Title 70 Revised Code of Washington section 70.41.90 and section 248-18-440

Wisconsin

Should a healthcare provider cease practice or business as a healthcare provider, the healthcare provider or the personal representative of the deceased healthcare provider shall do one of the following for all patient health records: A. Provide for the maintenance of the patient health records by a person who states, in writing, that the records will be maintained in accordance with state statutes. The custodian of the medical

records will provide written notice to each patient or patient representative describing where the records will be maintained and by whom. This notice will be sent by first-class mail to the patient's last known address. A class 3 notice will be placed in a newspaper in the county where the healthcare provider is located. B. Provide for the deletion or destruction of all or part of the patient health records. The provider or representative shall provide written notice to each patient or patient representative via first-class mail addressed to the patient's last known address, and by publishing a class 3 notice in a newspaper located in the county where the healthcare provider is located. The patients will be provided at least 35 days prior to the deletion or destruction of the records to obtain their medical records. This statute only applies to independent practitioners who cease practice or who die; it does not apply to residential facilities, nursing homes, hospitals, home health agencies, tuberculosis sanitariums, or public health agencies. Wisconsin Statute 146-819

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Appendix D: Retirement Preparation Questionnaire

This questionnaire from Marge Powers is a seven-point checklist that will help you determine whether you are prepared to manage your transition into retirement and whether you have developed a strategy for a rewarding lifestyle. (1)

Seven-point checklist, what matters now?

The following questionnaire will help you determine if you are prepared to manage your transition into retirement and, if you have developed a strategy for a rewarding lifestyle.

Mark each statement with the answer that best matches your answer; “Mostly, Partially, or Not.”

At the end of this questionnaire you will find a self-evaluation that will provide you with helpful insight to your answers.

1. I am clear about who I am, what motivates me, and my attitudes:

I know the major accomplishments in my retirement, work, civic, and family lives.

I know my primary capabilities, skills, talents, and expertise

I know the priorities that interest me in the areas of work, learning and, leisure.

I know what qualities characterize my behavior.

I'm aware of my most important values and beliefs.

I love and value myself.

I have a positive outlook on Me.

I try to learn from my mistakes.

I have a sense of humor and know how to have fun in my life

2. My relationships with family, friends, and associates are clear and prioritized:

I know how I innately learn and process data, and how I reach Decisions

I know how to ask for what I want

I pay attention to emotional needs

I have nurturing relationships

I continually develop my communication and listening skills

I belong to a positive support group

3. I am clear on my retirement and/or work plans and intend to continue “making a difference:”

I have an entrepreneurial attitude.

I have an interest in civic leadership.

I have an interest in mentoring, teaching, or consulting.

I have a small business interest.

I want to work part-time.

4. My financial plans are in order:

I can forecast my annual expenses

I can forecast my annual income

My assets and investments are allocated to my satisfaction

My estate and tax plans are set

5. My learning and leisure priorities are clear;

I know how to relax.

I know how I want to continue my education, formally and/or experientially.

I know where and how I want to travel.

I'm clear on which leisure and recreational activities I wish to continue or develop.

I am interested in learning new things.

6. I have decided where I want to live in order to implement my plans and achieve my goals:

My relationship priorities will be met.

My life work priorities will be met.

My finances will support my plans.

My educational priorities will be met.

My leisure priorities will be met.

The geographic area will fit my needs.

7. My commitments to my health and wellness standards are clear:

I do not smoke.

I drink moderately, if at all.

I am eating nourishing foods.

I am exercising.

I have annual checkups.

I handle stress effectively.

1. Powers M. *Winning Ways to Retirement Possibilities: Your Personal Discovery System*. San Jose, Calif: Winning Ways, 2000. (www.discoverwinningways.com)

FAMILY PHYSICIAN RETIREMENT SURVEY (full version)

This survey was sent to 2,000 randomized members of AAFP over the age of 50.

Analysis of the 831 that responded to the questionnaire is as follows:

Gender: Male **89.7%** Female **10.3%**

Age: Under 50 **0.3%**
 50-59 **43.6%**
 60-69 **18.1%**
 70-79 **28.1%**
 80+ **9.9%**

Aggregate findings:

1. Are you now fully or partially retired? Yes **43.0%** No **57.0%**

If yes, at what age did you retire?

Under 50	0.6%
50-59	10.5%
60-69	50.0%
70-79	35.8%
80+	3.1%

Was it: Full retirement **66.4%** Partial retirement **33.6%**

2. If not retired, at what age are you considering retirement?

50-59	12.6%
60-69	61.6%
70-79	21.5%
80+	4.3%

Will it be: Full retirement **39.8%** Partial retirement **60.2%**

3. What are your major concerns about retirement? (Please check three that are most important.)

54.9% Won't have enough money my time	12.4% Will not know how to spend
30.0% Will become bored	10.2% Relationship with my spouse
30.0% My health	15.3% Future care of my patients
22.7% My patients don't want me to retire	5.3% Don't have other interests
23.7% No longer making a contribution to society	13.8% Other, please specify:
29.2% Keeping up with medicine	

4. What were your major reasons for retiring or considering retirement? (Please check three that are most important.)

22.5% Burned out	17.2% My health
28.4% Spend more time with my family	34.5% Managed care frustrations
37.9% Government impact on medicine	21.9% Practice management issues
9.3% Time to read	35.1% Time to travel
38.0% Want to pursue other interests	17.1% Other, please specify:

Question 3: What are your major concerns about retirement?

No concerns	30
Will miss practicing	10
Family expenses, putting kids through college	8
Lack of health insurance	8
Will miss patients	7
Loss of status/feeling unimportant	6
General finances, lack of savings/retirement plan	6
My health	5
Loss of mental ability	5
Will miss colleagues/attending meetings	5
Finding time for everything	5
Finding ways to fill time/new interests	4
Unable to work part time due to malpractice insurance costs/fear of litigation	4
Difficulty finding part-time work	4
Learning a new business/career	3
Moving – where, whether to, readjusting	3
No appropriate MD replacements	3
Concern for future of family medicine	3
Health of spouse/family	2
Lack of focus (too many interests)	2
Finding new friends	2
Travel	2
Being burden on family	1
Lack of long-term care insurance	1
If patients want me to retire, I'm losing my ability to practice	1
More time with grandchildren	1
More time for tennis	1
More time for home improvement, fishing, music	1
More time with spouse	1

Question 4: What were your major reasons for retiring or considering retirement?

Threat of malpractice suits/litigation	18
To live and enjoy life/lessen stress/slow down	13
Pursue other interests/new career	12
Wanted to spend time volunteering (U.S. or overseas)	11
Health problems/disability	10
Realized it was time	10
Cost of business/malpractice insurance	10
Forced out/facility closed/no fitting opportunities	9
Age	9
Difficulty keeping up with changes	8
Feared losing ability to perform at highest level	7
General work frustrations (employer, unfriendly atmosphere, insurance)	7
Not considering retirement	6
Paperwork/regulations	5
Sold practice	4
Need to care for other family members	4
Dissatisfied with direction health care is going	3
Hospitalists	3
HMOs	3
Financially able	2
Employer offered retirement incentives	2
Lack of malpractice/liability insurance	2
Frustration with academic medicine	2
Pressure from addicts to pain meds – retired to avoid them	1
Returned to college	1
It won't come soon enough	1

Question 5: What products or services could the AAFP provide that would be of value to you as you make this transition?

Placement service: part-time jobs, volunteer opportunities, locum tenens	71
Money management advice (reliable, unbiased)	62
Already retired/nothing	44
Products (health/life/long term care insurance, drug coverage, malpractice coverage, well-managed retirement fund)	40
Continue providing journals, meeting notices	32
Articles in <i>AFP</i> regarding retiree issues	23
Seminars on retirement planning	20
Ways to prepare oneself for retirement	17
Reduce hassles (insurance/government/HMOs)	16
Continue CME programs	15
Advice from/experiences of retired FPs	15
AAFP retired division/retired FP organization/links to those who have retired	13
Discounts (membership dues, CME, meeting fees, etc.)	11
CME programs (retirement issues/estate planning)	9
Advice on closing/selling practice	9
Change legislation so physicians can work part-time or volunteer (cost of malpractice insurance):	9
Encourage young physicians to plan early	6
Help in finding a successor	5
Send money	4
Make available a practice management model/info to help physicians with business issues	4
How to leave patients/transition to new doctor	3
Annual or quarterly publication for retired FPs	3
Recommend lawyers/develop programs to help deal with contract issues and reimbursement	3
Counseling services (financial planning, career changes)	2
Relocating/where to move	2
Organize group tours/activities; retirement communities for FPs	2
Legal aspects of keeping records	2
Review of long-term care insurance policies	2
Increased reimbursement	2
National initiative to create FP retirement fund	2
Make CME available on the Internet	1
Record of CME hours	1
Research/recommend good retirement software	1
Take my calls for the next 2 years	1
Set up corps of physicians to work in age appropriate styles of practice	1
Program to certify retired physicians for teaching	1
Referral list of specialists by region to satisfy health needs of retired doctors	1
Advice for competing against HMOs	1

Continue push for long-term care and prescription drug relief	1
Help to get tax breaks for home repair	1

Question 6: What advice would you give to physicians who are considering retirement?

Plan <u>before</u> you retire (second career, hobbies, travel, etc.)	167
Develop a good financial plan and start saving early	159
Use medical talents (volunteer, work/teach part-time)	76
Don't retire (work as long as able/enjoyable)	54
Exercise; maintain your health	36
Retire gradually (partial retirement)	33
Consider what's best for <u>you</u>	31
Do it	28
Stay involved with medicine (journals, local meetings, CME courses)	25
Contribute time to activities outside of medicine	25
Enjoy family/friends	24
Retire as soon as financially able	22
Prepare mentally, spiritually	21
Relax, enjoy life	21
Retire while young and healthy	20
Keep your mind active (read, education courses)	14
Seek expert financial advice	12
Learn to live on budget	7
Do what's best for patients (if you can't keep up or offer highest quality care, retire)	6
Consider moving; spend time in that community before actually moving	5
Stay in touch with patients and colleagues	4
Prepare for status change	4
Stay out of your spouse's way	4
Retire quickly (full retirement)	4
Plan for health expenses	3
Diversify investments	2
Plan carefully for record storage, availability, etc. in compliance with laws	2
Bring in a partner your patients will like; have transition period	2
Be ready to feel guilty for awhile; try not to	2
Learn computers	2
Discuss retirement plans with family	2
Membership dues are harder to pay when you have little or no income	1
Don't put money away to pass down to your children	1
Stay out of stock market	1
Sell out to a larger clinic or hospital to get the best price	1
Incorporate if feasible	1
Have lawyer lottery insurance	1
Transition to administrative medicine	1
Maintain equanimity	1
Read the book "Halftime"	1
In most cases, insurance "tail" prevents doing anything medical after retirement	1
Stay single	1

Retirement Survey

Findings by age category:

1. Are you now fully or partially retired?

	<50	50-59	60-69	70-79	80+
Yes	1 (33.3%)	24 (6.6%)	62 (41.3%)	192 (82.4%)	78 (95.1%)
No	2 (66.7%)	338 (93.4%)	88 (58.7%)	41 (17.6%)	4 (4.9%)
If yes, at what age did you retire?					
Below 50			2 (3.3%)		
50-59		21 (100.0%)	7 (11.7%)	6 (3.4%)	
60-69			51 (85.0%)	90 (50.8%)	21 (31.8%)
70-79				81 (45.8%)	35 (53.0%)
80+					10 (15.2%)
Was it:					
Full retirement		8 (36.4%)	37 (62.7%)	114 (62.6%)	66 (88.0%)
Partial retirement	1 (100.0%)	14 (63.6%)	22 (37.3%)	68 (37.4%)	9 (12.0%)

2. If not retired, at what age are you considering retirement?

	<50	50-59	60-69	70-79	80+
50-59		50 (16.4%)			
60-69	2 (100.0%)	209 (68.8%)	32 (45.1%)	1 (5.3%)	
70-79		40 (13.2%)	35 (49.3%)	10 (52.6%)	
80+		5 (1.6%)	4 (5.6%)	8 (42.1%)	
Will it be:					
Full retirement	1 (100.0%)	107 (38.4%)	31 (45.6%)	9 (39.1%)	
Partial retirement		172 (61.6%)	37 (54.4%)	14 (60.9%)	1 (100.0%)

3. What are your major concerns about retirement?

	<50	50-59	60-69	70-79	80+	Sig.
Won't have enough money	1 (33.3%)	260 (71.8%)	73 (48.3%)	94 (40.3%)	28 (34.1%)	p=<.001
Will become bored	1 (33.3%)	99 (27.3%)	59 (39.1%)	76 (32.6%)	14 (17.1%)	p=.002
My health		101 (27.9%)	39 (25.8%)	72 (30.9%)	37 (45.1%)	p=.012
My patients don't want me to retire	2 (66.7%)	55 (15.2%)	44 (29.1%)	64 (27.5%)	24 (29.3%)	p=<.001
No longer making a contribution to society		64 (17.7%)	44 (29.1%)	72 (30.9%)	17 (20.7%)	p=.001
Keeping up with medicine	1 (33.3%)	78 (21.5%)	48 (31.8%)	83 (35.6%)	33 (40.2%)	p=<.001
Will not know how to spend my time		44 (12.2%)	20 (13.2%)	32 (13.7%)	7 (8.5%)	
Relationship with my spouse		45 (12.4%)	9 (6.0%)	24 (10.3%)	7 (8.5%)	
Future care of my patients	1 (33.3%)	33 (9.1%)	34 (22.5%)	44 (18.9%)	15 (18.3%)	p=<.001
Don't have other interests		18 (5.0%)	11 (7.3%)	11 (4.7%)	4 (4.9%)	

4. What were your major reasons for retiring or considering retirement?

	<50	50-59	60-69	70-79	80+	Sig.
Burned out	1 (33.3%)	109 (30.1%)	40 (26.5%)	28 (12.0%)	9 (11.0%)	p=<.001
Spend more time with my family	1 (33.3%)	124 (34.3%)	44 (29.1%)	49 (21.0%)	18 (22.0%)	p=.003
Government impact on medicine	2 (66.7%)	97 (26.8%)	47 (31.1%)	124 (53.2%)	45 (54.9%)	p=<.001
Time to read		41 (11.3%)	8 (5.3%)	20 (8.6%)	8 (9.8%)	
Want to pursue other interests	1 (33.3%)	179 (49.4%)	55 (36.4%)	62 (26.6%)	19 (23.2%)	p=<.001
My health	1 (33.3%)	42 (11.6%)	28 (18.5%)	43 (18.5%)	29 (35.4%)	p=<.001
Managed care frustrations	2 (66.7%)	103 (28.5%)	51 (33.8%)	100 (42.9%)	31 (37.8%)	p=.003
Practice management	2 (66.7%)	75 (20.7%)	27 (17.9%)	59 (25.3%)	19 (23.2%)	

issues						
Time to travel	1 (33.3%)	151 (41.7%)	55 (36.4%)	63 (27.0%)	22 (26.8%)	p=.001

Retirement Survey

Findings by gender:

1. Are you now fully or partially retired?

	Female	Male	Sig.
Yes	20 (23.5%)	335 (45.2%)	p<.01
No	65 (76.5%)	406 (54.8%)	
If yes, at what age did you retire?			
Below 50		2 (0.7%)	
50-59	6 (33.3%)	28 (9.2%)	
60-69	11 (61.1%)	150 (49.2%)	
70-79	1 (5.6%)	115 (37.7%)	
80+		10 (3.3%)	
Was it:			
Full retirement	14 (70.0%)	211 (66.6%)	
Partial retirement	6 (30.0%)	106 (33.4%)	

2. If not retired, at what age are you considering retirement?

	Female	Male	Sig.
50-59	10 (17.2%)	40 (11.9%)	
60-69	38 (65.5%)	204 (60.7%)	
70-79	9 (15.5%)	76 (22.6%)	
80+	1 (1.7%)	16 (4.8%)	
Will it be:			
Full retirement	25	122	

	(49.0%)	(38.1%)	
Partial retirement	26 (51.0%)	198 (61.9%)	

3. What are your major concerns about retirement?

	Female	Male	Sig.
Won't have enough money	52 (61.2%)	403 (54.3%)	
Will become bored	20 (23.5%)	228 (30.7%)	
My health	21 (24.7%)	228 (30.7%)	
My patients don't want me to retire	17 (20.0%)	169 (22.8%)	
No longer making a contribution to society	27 (31.8%)	170 (22.9%)	
Keeping up with medicine	28 (32.9%)	214 (28.8%)	
Will not know how to spend my time	10 (11.8%)	93 (12.5%)	
Relationship with my spouse	4 (4.7%)	81 (10.9%)	p=.07
Future care of my patients	7 (8.2%)	118 (15.9%)	
Don't have other interests	2 (2.4%)	42 (5.7%)	

4. What were your major reasons for retiring or considering retirement?

	Female	Male	Sig.
Burned out	21 (24.7%)	165 (22.2%)	
Spend more time with my family	34 (40.0%)	201 (27.1%)	p=.06
Government impact on medicine	20 (23.5%)	293 (39.5%)	p<.01
Time to read	12 (14.1%)	65 (8.8%)	
Want to pursue other interests	34 (40.0%)	280 (37.7%)	
My health	16 (18.8%)	126 (17.0%)	

Managed care frustrations	22 (25.9%)	263 (35.4%)	
Practice management issues	14 (16.5%)	166 (22.4%)	
Time to travel	33 (38.8%)	257 (34.6%)	

RETIREMENT SURVEY Open-ended Responses

3. What are your major concerns about retirement? Other:

- 015 Just another retired “Joe.”
- 019 Health of spouse.
- 025 I love my job.
- 027 Have not cultivated an adequate number of friends with whom to do things in retirement. Most friends are doctors who are still working.
- 029 I like it.
- 034 Transitioning to new “peers” – finding new friends with similar interests.
- 058 No particular concern.
- 062 Traveling.
- 063 Having time for children, grandchildren and wife.
- 065 Too many interests.
- 068 Will financially need to work until youngest (now age 4) through college.
- 069 Health care for me.
- 086 Too many other interests – I may become scattered.
- 091 Young kids at home.
- 111 Insurance coverage for my younger wife.
- 112 I would like to find appropriate replacement. I own office; good neighborhood, busy practice.
- 114 I have been retired 4 years, have no hobbies, do not play golf, hunt, fish, play cards and yet I love to read, travel with my wife, do some yard work, do nursing home and home visits for the enjoyment they and I get out of it. I waste some time and enjoy every minute.
- 125 None; none of above.
- 131 Only the one (money) is a concern.
- 135 No concerns.
- 153 More time with grandchildren.
- 154 None of the above.
- 156 Won’t be able to contribute part-time because of malpractice costs.
- 162 Longevity.
- 167 Will miss patients and using talents!
- 178 No major concerns.
- 180 I really had no concerns!

- 182 Will miss my colleagues.
- 190 Not concerned. I try to stay healthy and will work as long as I am able – I am a physician.
- 192 Want to develop other focuses.
- 193 Don't have any concerns related to retirement, but one is always concerned about health whether retired or not.
- 208 Transition from 12-14 hr days to ?
- 211 11 year old son.
- 215 None.
- 234 Fear of not being able to partially retire.
- 253 None apply – no major concerns.
- 254 Developing new interests.
- 257 Lack of stimulation.
- 258 Fear of loss of mental ability to read, etc. through dementia.
- 259 Use it or lose it (brain).
- 267 Changing to new medical care (physicians) and facility (hospital) in moving to new community to live.
- 269 Money is the only factor that keeps me from retiring now.
- 276 Fix it (big house), fishing (off shore), music, piano.
- 282 The general problems of the aged!
- 288 Health insurance.
- 296 Practice gives meaning to my life.
- 301 None of the above.
- 311 HMOs robbed me; robbed my profession from me. Unable to ethically practice medicine under an HMO environment.
- 316 Manpower to keep the practice going.
- 321 No concerns.
- 325 I enjoy the practice of medicine and enjoy serving my patients.
- 329 Although I am now working as Surgical First Assist I miss terribly patient contact and care. I feel the experience physicians such as I have is an untapped resource available to many aspects of the community.
- 330 None.
- 332 Will lose sharpness of mind.
- 336 Not enough time in the day to do all the things I want to do.
- 339 I deal with a bit of each of the above, but mostly enjoy the “dealing,” and am glad to be in this time of my life.
- 344 I'm leaving managed care (Indian Health Service) for part-time private practice – there's lots of “business office” things I don't know.
- 363 Self identity as a physician.
- 368 No education on how to plan for retirement.
- 370 If I will be well enough to pursue my other interests aside from medicine.
- 371 No major concerns.
- 375 Will miss visiting with patients.
- 376 Medicine is fun and useful.
- 386 None.

- 387 The sad state of medicine. I keep track of a large number of friends and old patients.
- 395 Learning enough about blueberries to make the blueberry farm economically viable.
- 405 Difficulty finding paying part-time (2 days/week) job.
- 409 Entering second career – none of the above.
- 412 None of the above.
- 413 Buying health insurance.
- 431 Miss patient care.
- 443 No concerns.
- 445 Missed the doctor-patient relationship. Missed the drug representative meetings and my colleagues.
- 451 Miss medical meetings, etc.
- 457 Will I be financially free of family obligations (college, etc.)?
- 470 Finding time to do all that I want to do!
- 473 No concerns.
- 479 Lack of health insurance until Medicare age.
- 493 Desire to spend more time with my wife.
- 509 Socialization/isolation.
- 515 I want to keep my mind active.
- 517 I truly enjoyed practicing medicine and my patients.
- 518 None.
- 526 None!
- 527 Health of family members.
- 529 Recent collapse of financial market.
- 530 Having to quit what I loved best. Remember one can't do just a little FP, one must be prepared to cover the front.
- 538 I'd be giving up something I enjoy.
- 542 The difficulty in offering care to the indigent forced me into full retirement.
- 552 It is hard not to be contributing.
- 555 Health insurance.
- 564 None.
- 570 Loss of contact with peers.
- 578 Liberal socialistic democrats taking over medicine!
- 579 Keep some way of living specially _____.
- 589 1) Will miss my patients. 2) Health insurance. 3) Long-term care.
- 597 More time playing tennis.
- 606 None of the above. (Retirement from family practice doesn't mean one stops living.)
- 636 No concerns. I am very happy with my retirement.
- 645 I worked for 20+ years in Latin America – began back in USA at 51 yrs. with no savings, big debts.
- 650 I enjoy what I'm doing.
- 652 I don't plan to fully retire, but getting part-time work is hard.
- 655 No savings after 11 years of practice.
- 663 Have a son to put through college.

- 668 How to find enough time to do all I want to do!
 677 Will miss medicine.
 686 Will miss family practice.
 694 None of the above.
 695 Too much energy to quit!
 701 Whether to move.
 708 Where to retire to.
 735 Don't want to become a burden on my family.
 742 No concerns about retirement.
 743 Children's college education.
 745 I enjoy taking care of patients.
 748 I work in a town of 600 in a MVA – unlikely that any physician would take over.
 755 If so (if patients want me to retire), losing my ability to practice.
 756 2 kids to put through college.
 757 No concerns.
 771 I have so many other interests; which will I start? That is, doing all the things I want to do.
 772 Guilt complex associated with being nonproductive.
 777 More travel.
 783 Want to continue utilizing my medical experience in an unorthodox setting – but can't find one!
 785 Coding!
 787 Fracture of hip, severe peripheral neuropathy prevents previous plans – golf, etc.
 790 I don't worry – I'm just thrilled.
 793 Litigation issues.
 794 None.
 797 Health insurance.
 808 I have two other companies that I am CFO. For the last 4 years of my practice, my income came from them.
 815 How to do some part-time work.

What were your major reasons for retiring or considering retirement? Other:

- 007 I knew I was financially able and would have income at \$110,000+ per year.
 016 Emphasize rising above income.
 018 Was able to sell my practice and stay as long as I wanted.
 021 Ability to perform to my expectations.
 022 Litigious society.
 028 Frustration with academic medicine.
 029 Lawyers.
 031 Not yet considered.
 032 Lack of malpractice insurance; St. Paul quit.
 039 Clinic voluntary work.
 043 I didn't take HMOs.
 052 Age, malpractice insurance, poor memory.

- 053 Myocardial infarction.
- 054 Live life!
- 065 Being able to keep up with all of the new stuff!
- 066 Malpractice threats.
- 067 Inability to continue meaningful employment (forced out).
- 068 If I could financially do it I would work ½ time until age 70.
- 071 Too much paperwork.
- 074 See below.
- 084 Want to do missionary work.
- 086 Want to do more public health work rather than office practice.
- 089 Not able to get liability insurance.
- 101 Malpractice concerns.
- 110 Cost of malpractice insurance in Emergency Medicine.
- 111 Time to write.
- 112 After 31 years of practice I want time to enjoy life, without patient responsibility.
- 114 Realized my time in medicine was over.
- 120 Employer offered retirement incentive.
- 131 Only the one (health) really counts although 2 others (managed care frustrations and practice management issues) were a part but could be lived with.
- 135 65 years old and time to retire.
- 139 Decreased reimbursements and increased overhead.
- 150 Decrease in ability.
- 152 Medico-legal issues.
- 160 Cancer and congestive failure due to chemotherapy.
- 163 Early retirement offer with perks.
- 166 Negative impact of hospitalists, hospital employment w/ all new physicians in area.
- 167 Time to develop new challenges and pursue other interests.
- 171 Liability and malpractice.
- 175 Age, difficulty keeping up when partially retired.
- 180 Full time artist.
- 187 For me, 40 years was sufficient work.
- 190 All of these apply, but I try to balance work, family and church now.
- 192 Work frustrations.
- 193 Age.
- 199 Better enjoy life; do what you've always wanted.
- 201 Wife recently ordained, I'll go with her but plan to work a 0.6 equivalent.
- 206 Back to college.
- 219 Health was really the only reason.
- 232 Paperwork, documentation to avoid malpractice, paperwork, paperwork, paperwork.
- 243 Volunteered at overseas medical clinics.
- 249 I enjoyed family practice all my practice years – the frustration of government and HMOs, etc. were not enough to make me want to quit. My reason for retirement was to be sure my patients received excellent care. During my years in practice I saw too many physicians who refused to retire even though they were

- years behind the times. Early in my career I decided to retire while my brain was still functioning. I have also enjoyed retirement.
- 266 Hospitalists.
- 267 Help with quadruplet grandchildren.
- 268 To take care of my wife, who had terminal cancer.
- 278 Malpractice.
- 282 Had a CVA. All symptoms improved, but retired.
- 289 Felt I was “losing it” and should retire.
- 290 Liability concerns.
- 294 Want to return to part-time medical missions.
- 296 Not considering retirement at this time.
- 300 Medical liability.
- 301 Threat of malpractice lawsuits – cost of insurance.
- 309 More fun.
- 320 It was time! (age 67)
- 324 Having free time to decide and do whatever I want to do.
- 325 Regulations, paper work. Seeing and caring for patients is fun.
- 328 My wife had a stroke, and to keep her at home, I had to become the main caregiver, which is full time.
- 329 Was employed full time as chief of staff national HMO that closed its local operations. At 75 I did not want to start private practice over again so I went to surgery assisting.
- 330 I felt age 70 long enough to practice.
- 334 More difficult keeping up.
- 338 Partial – age 66. Full – facility closed.
- 339 I was so angry at the intrusion of government and insurance co. staff and PAPERWORK. It required a double coronary artery bypass. Anger is hard on one’s health and happiness (and coronaries).
- 340 Expenses associated with solo practice (e.g. med insurance, rent, office supply).
- 342 Time to move on.
- 343 Fear of not keeping up medically.
- 344 I’d like to work only 40 hours/wk.
- 345 Why I left a 22 year practice to return to active duty (USAF).
- 349 TIRED (physically).
- 373 Too old.
- 381 It was time to retire.
- 396 Age.
- 402 None presently.
- 409 Overqualified for practice opportunities.
- 413 Unfriendly atmosphere at local hospital.
- 423 I thought I was burned out, but 6 years later I found out I had a parathyroid tumor which had been causing my symptoms for several years. I am now ready to return to practice at age 71 ½.
- 431 Wanted to teach.
- 435 Employer problem.
- 440 I was bought out by a group practice without walls that went bankrupt.

- 443 Care is changed. Care today must be within physician's convenience.
455 Like to contribute in some area other than rural care primary doctor.
460 Malpractice threats.
475 Depression – wife left, divorce.
480 AMA Board, pres. AMA.
487 No interest in retirement anytime soon.
490 Couldn't keep up with more rapid changes. Most doctors are now more interested
in diseases and conditions than in the patient.
497 Age.
502 Inability to negotiate a reduced call schedule with associates.
517 Complete change in lifestyle and home. The great effort to keep up with rapid
changes.
520 The bureaucrats drove me out!
526 No schedule, time my own.
527 Malpractice issues.
528 Contribute to others voluntarily.
530 My partner (eight years my junior) retired. I couldn't do the practice of two
doctors – I did not want to retire until I had practiced 50 years (I did 46 ½).
538 Other challenges, i.e. teaching.
539 I felt I was not staying sufficiently informed to practice safely.
555 Legal issues/liability/always worrying about potential for lawsuits.
563 Age.
571 Lack of support for FP by medical education institutions, managed care
discrimination.
579 Do nothing.
584 To work as medical missionary to Kenya.
587 Fear of lawsuits.
591 Concern for future of medicine – multiple third parties, “one size fits all”
government policies.
598 30 years was enough. Not one big thing but many little ones.
619 Rest.
620 Wife tired of being alone.
622 Liability concerns.
626 Started a book business.
655 Unable to practice a full spectrum of family practice due to specialists in the area.
658 Medical mission.
660 To give more free community service.
669 _____ for retirement age.
673 I took in one new family physician every year for five years, and then there
wasn't any room for me.
676 High cost of practice and poor reimbursement.
683 Legal concerns (malpractice).
686 Spend time with family, medical mission work.
697 Age. I don't want to become incompetent while in practice.
698 Lawyer's lottery.

- 708 By that time in life (70) I can't see myself spending enough time to keep up – would rather have the freedom to live outside of medicine.
- 712 It won't come soon enough!
- 726 Managed care is a major block to good health care.
- 727 Not Boarded. Fear of being sued.
- 729 High cost insurance.
- 734 Sold my office – building.
- 735 Believed that I was getting too old to deal with the recent advances and the new medications.
- 737 Disability.
- 740 Poor income. Unable to practice limited amount.
- 760 Age.
- 764 Legal complications.
- 765 Son finished residency in family practice. He only lasted 10 mos. in private practice.
- 768 Not applicable yet.
- 769 No plans, circumstances may dictate eventually.
- 771 I want to retire before my arthritis prevents me from doing what I want to do.
- 774 Hobbies.
- 780 Lessen daily stress.
- 783 I closed my practice May 2000 after discovering embezzlement and struggling for years. I am doing entertainment, edutainment, and health/wellness presentations now. (Cincinnati has become an utterly MISERABLE place to practice medicine! I'm told we're third worst in the U.S. for reimbursement.)
- 787 Fracture of hip, severe peripheral neuropathy.
- 794 Spouse's health.
- 802 Hassle factors.
- 804 It was the right time.
- 807 Business – unable to compete with HMO and capitalization level. Sold out business to HMO.
- 817 Pressure from addicts to pain medication. Best way to avoid these people was to retire completely, and time had come anyway (age 84).
- 819 Slowing down is not affordable due to overhead.
- 823 Not being on call! Having to dictate nightly.

What product(s) or service(s) could the AAFP provide that would be of value to you as you make this transition?

- 001 Travel options
- 003 Continue supplying medical journals and pg (sic) material.
- 015 Keep on sending to me *American Family Physicians* so that I can continue CME to maintain my state license.
- 016 Money management info.
- 018 Too late.
- 022 CME programs.

- 027 Partial retirement brochure addressing issues in question 3. Another major concern is health insurance coverage and bridging the time from retirement until one can begin withdrawals from retirement accounts, IRA, etc.
- 030 Bring on a new generation of FPs to replace us.
- 031 None.
- 033 AAFP – Retired division.
- 034 AAFP could stress early retirement planning even as early as residency. Retirement package like part of recruiting.
- 035 Conduct comprehensive retirement planning programs.
- 038 How to develop other interests.
- 041 *American Family Physician* and CME study course are most appreciated.
- 042 Doubt you could do any more than you have done or plan to do.
- 043 Travel with other physicians. CME. How to reduce travel \$.
- 047 Placement services for “retired” doctors who could volunteer services for – disasters, good works, underserved areas.
- 049 Continue the mail so I can go to meetings.
- 052 None – I do volunteer work at clinics and hospital – medical care -- two to three days a week. Only retired six months ago.
- 054 Do something about these third party payers, if you could please.
- 055 Seminars, periodicals, articles in *AAFP Journal* regarding retirement issues, i.e., planning for retirement, potential disappointment, ways to slow down without full retirement, new careers, financial, travel, etc.
- 058 None needed.
- 059 Retirement investment advice.
- 060 Counseling services.
- 062 Retirement organization for FP.
- 067 Job appointments half time. How to invest for income.
- 069 Opportunities for volunteer service – here & abroad.
- 071 See # 6.
- 072 Penny stock well-managed fund.
- 074 None at present. I am disappointed that the time, effort & money spent to become board certified & re-certified has meant nothing. Reimbursement has not been any different. Managed care pays more for billing with a computer than it does for Board Certification.
- 075 Sources of income.
- 077 Appreciate information regarding services.
- 079 Ideas of volunteer positions where family practitioner skills could be used beneficially in US or around the world.
- 080 How to close a practice.
- 081 So far you are doing great. The AMA looks sick by comparison.
- 083 Life insurance products that continue into retirement.
- 084 My company has a corporate deferred income (non-qualified retirement) plan. Could you duplicate this for FPs in companies that don’t offer it? Help FPs with part-time and/or short term job placements.
- 086 Projects that I could work on that would better the public’s health, strengthen the AAFP, use my expertise.

- 087 None at present – but health insurance affordable before Medicare may be useful.
- 088 Directory of volunteer opportunities and short-term part-time medical jobs.
- 089 Kill the attorneys?! Kidding.
- 090 Help reduce “hassle factor” from managed care and insurance companies so we can practice medicine and spend less time on business!
- 091 Information to financially prepare for retirement. Different ways to partially retire – i.e. fewer days versus shorter hours versus limiting practice size, etc.
- 092 Investment advice and money management guidance.
- 094 Articles about retirement.
- 096 Possibly a directory of sorts to point out medically related positions.
- 097 None. Thank you.
- 101 Not Sure.
- 104 1) Provide a list of locum tenens; 2) Aid in recruiting a young MD.
- 105 Opportunities for part-time work, malpractice coverage, etc.
- 107 Unknown.
- 110 Listing for areas to volunteer.
- 111 Seminar-things to consider, groups of similar physicians.
- 112 I would like information on current ‘2002’ year trends in “sale of practice.” Hospitals don’t have same interests as they did 5-10 years ago. I have urban practice/place in good area of Queens, NY. I also own office.
- 113 *AFP* journal.
- 114 I’ve already done it.
- 116 Seminar on planning for psychosocial aspects of retirement.
- 117 Options for part-time employment.
- 118 Setting up a medical volunteer program in conjunction with an established organization – i.e. church mission.
- 120 Continuing education, reduced dues.
- 122 I have not done it yet but I would not be bored. I have so many things to do and enjoy life.
- 126 Retired 2+ years ago.
- 129 Money.
- 130 Publish a list of physicians looking for a practice.
- 132 Give us information regarding appropriate volunteer activities to make use of our experience and training.
- 134 A lower fee or none at all for attending meetings (scientific or otherwise).
- 135 I have already been retired 18 years and have enjoyed every one of them.
- 138 Careers after retirement-options like volunteer service, etc. – ways to keep sharp but still slow down.
- 139 Continue CME programs, especially in *AFP* Journal.
- 141 Why not develop a core of physicians that could continue to work and contribute in age appropriate styles of practice?
- 142 I would like to have some ideas on how to cut the practice down from 80 hour/week practice to 35 hour/week practice without the headache and hassle of taking on a partner!
- 143 Investment strategies.

- 144 National initiative to induce employers to contribute to employee physician retirement programs.
- 145 Health insurance for members, reduce dues for retirees.
- 146 Continue medical information.
- 148 Continue your great *AFP Journal*.
- 149 None. What AAFP needed to do was prevent CLIA, STARK, HIPA, etc.
- 154 None. You have to do it yourself. The Academy cannot retire for you – first it is a “state of mind,” then “action.”
- 155 Thank you for the *Journal of American Family Physician* that keeps me up to date and allows CME hours to keep my medical license active.
- 161 Updates on retirement programs – ways to contribute after retirement – money management.
- 162 Investing for retirement.
- 164 Satisfactory health insurance; good CME programs; special referral list of specialists in local area to satisfy my needs.
- 166 Guidance in buying/selling a practice.
- 168 Reduced membership fees so I’d have more money to place in IRA.
- 170 Financial and asset management.
- 171 Valuable to me was a symposium on retirement a few years earlier, especially on finances.
- 172 Continue to receive the *AFP Journal*.
- 175 Meaningful charity services in or out of medicine.
- 179 Retirement seminar.
- 180 I’m satisfied and happy!
- 181 Booklet of “advice.”
- 185 Realistic appraisal/information on what the average FP in practice now can expect to need financially in 10-15 years.
- 186 Roll-over of IRAs.
- 187 Emphasis on: financial independence; other interests for retired FPs; maintaining good health.
- 188 Experiences of other physicians who have retired.
- 189 CME that helps you keep up; financial planning; options for retired FPs (patterns and job opportunities).
- 192 Broad array of information outside of medicine.
- 193 Loss of perquisites and lack of professional courtesy – dealing with government agencies, etc. are problems. AAFP might organize retirees to deal with problems, provide group recreational activities, ombudsman service, etc.
- 195 Reduced fee at medical meetings.
- 196 Group health insurance. Part-time placement service.
- 198 Continue the excellent continuing education program.
- 199 Can’t really think of any – by now it’s getting a little late.
- 201 Am I OK to retire? How do I learn not to work 60-80 hr. weeks?
- 207 Volunteer services or locum tenens.
- 208 Make all issues of retirement available to me and alternatives to consider.
- 209 Volunteer opportunities available – and how to make contact.

- 212 Plot how much money is needed to have times money available and how much is needed – lots of variables but some generalities would be helpful.
- 214 Review of other avenues of productivity with flexible schedules.
- 215 Recognize cognitive time and reimburse for it.
- 216 Seminars that the Medical College of Wisconsin has for retired physicians are excellent and interesting.
- 217 Linkages to those who have retired.
- 218 Keep me up to date with recent medical advances by way of monthly magazine and publications.
- 220 Pre-retirement financial planning.
- 223 Record of CME hours.
- 224 Sooner or later everybody will need expensive medication. Could you possibly provide insurance at a reasonable price?
- 227 Appropriate course work to keep current.
- 228 Information addressing literature, travel and other interests for retired.
- 229 Places where service of retired physician is needed – domestic and overseas.
- 234 What are feasible, potential benefits?
- 241 Sensible plan with trustworthy administrator.
- 244 Help with reducing government impact.
- 246 AAFP has been great. Providing life membership, reduced registration fee for annual meetings and seminar on retirement at annual meeting.
- 251 1) Practice management model needs to be available. 2) AAFP needs to be more proactive in assisting physicians with above to make it easier for physicians to remain in practice.
- 252 Get rid of HMOs.
- 254 How about having a monthly geriatric article in AAFP concerning: hobbies, fishing, travel, sports, physical fitness, bicycling, stamp collecting, antiques, cooking (indoor and outdoor), gardening, shrine hospitals, clinics for kids, coin collecting, etc.
- 256 AAFP Quarterly Newspaper (pamphlet). I recommend “How to plan ahead” and suggestions on how to cope with retirement.
- 257 Anecdotes about retirees; fixed income investments; advantages and disadvantages of relocation.
- 258 None that come to mind after 10 years of retirement.
- 261 Information regarding satisfying full or part-time work related to medicine. For example, I am interested in medical writing. What’s available through the AAFP and other medical bodies producing journals and CME materials?
- 262 I did not intend to retire if it was not for the injury. I wish to go back to work after full recovery.
- 265 Provide info as to how we can still help in medicine – medical missionary work, volunteer at clinics, Indian reservations, etc.
- 266 Opportunities for service.
- 268 None, in my particular situation. In general, however, help physicians develop interests outside of their work. Many physicians need such help.
- 270 IRAs/403b etc. Estate planning, locums/travel for me.
- 271 Medical related activities, opportunities, information.

- 275 Volunteer opportunities.
- 276 The information about new things in medicine.
- 278 Ongoing seminars on the subject.
- 279 Opportunities for travel, events.
- 282 Continuation of the journals I am still receiving.
- 284 1) Continuing education with *AFP Journal* and monographs. 2) Continued recognition.
- 288 Recommendation for portfolio - % of bonds, growth stock or mutual funds – 5 years prior to retirement.
- 293 Health insurance for retired AAFP members!
- 297 Continue to push for long-term care and prescription drug relief. Continue your excellent publication for us.
- 300 Retirement seminars at annual meetings – investment and estate planning with caution – they become sales pitches.
- 301 Really none – is an individual problem.
- 303 Guide to (and some assessment of) retirement planning resources.
- 304 Continuing.
- 307 Already doing enough.
- 309 It's my business, isn't it?
- 312 Part-time opportunities.
- 315 Medical insurance.
- 316 Financial planning services for retirement.
- 317 Volunteer opportunities for retired physicians.
- 319 Some services are already provided.
- 320 Seminars on retirement.
- 324 Financial planning. Ways to keep up somewhat with medical issues. Various options for retired physicians who want to keep involved in some way with medical things.
- 325 I really have no problems.
- 327 Encourage life membership so that the excellent *AFP* magazine comes regularly (can keep up-to-date with this!)
- 328 1) Check out and advise on best long-term care insurance policies and contribute early. 2) CME courses to include estate planning.
- 329 We, the AAFP, need to establish a committee of seasoned, senior members who want to learn and explore all their late professional career options. We have many programs for those beginning their careers or in mid-career but nothing, to my knowledge, for those of us winding down our professional lives who might very well enthusiastically welcome professional options beyond golf, travel and rocking chairs. Last year, before the Annual Assembly I called and e-mailed a few times hoping to find support for my concerns and again, express my eagerness to serve on a committee, task force or commission to work in this field.
- 331 None at this time as I have transitioned into retirement for more than 20 years.
- 335 Forum for finding part-time work opportunities. Forum for finding volunteer/service medical opportunities.
- 337 Advice re: retirement financial plans – volunteer projects.

- 339 For many docs – dependable advice toward financial security (such as available through the Utah State Medical Association (UMA)).
- 344 I got the “On Your Own” book; I’m not looking at this as retirement really – I’m starting a new practice at age 55.
- 349 1) Education regarding retirement issues (business side). 2) Education regarding leaving patients (consoling patients). 3) Education regarding financing retirement years.
- 352 Help members appreciate their lives outside the field of medicine.
- 353 Need to know if financially I will be able to retire and still enjoy my lifestyle.
- 355 Catastrophic health insurance.
- 356 Knowing what other interests have developed after retirement – i.e. advice from those retired.
- 359 Financial plans and vehicles: Include in Journal – what’s new, etc. Overall I find the Journal excellent for me.
- 360 Some articles about: continuing to contribute to society; keeping up with medicine; ways to spend extra time; finding other interests.
- 363 Have made the transition and am quite comfortable.
- 367 Any retirement guides or specific advice for retiring family physicians. Data on satisfaction (personal) of partially retired and fully retired FPs.
- 368 Resources (on-line) to assist in retirement planning!
- 373 Continue periodical.
- 375 CME on retirement.
- 378 Don’t know – won’t be there for more than 10 years most likely. I’m considering 1) writing a novel; 2) politicking, I’d like to see a youth service corps become a bigger option; 3) traveling the USA with a geologist’s hammer and a good strong vehicle.
- 379 Continued fellowship and support.
- 381 Special magazine 4 times per year on issues – travel, finance, hobbies, volunteering, etc.
- 385 Options for disposing of assets, keeping chart files so they’re available for patients. (I have many patients whose previous docs left practice and patients can’t get hold of their records.)
- 386 Retired 1-1-88 – I had hobbies of travel, the stock market, and tour escorting for a senior travel group. I needed no help.
- 389 Offer volunteer work on a part-time basis.
- 390 None except continue to let government (managed care) know it is negatively impacting providers.
- 391 1) Retirement Checklist. “Make sure you have these things done.” 2) How can I partially retire? How can I get malpractice insurance?
- 394 Haven’t thought about it.
- 396 It would be nice to have an active chapter of AAFP in my area.
- 397 More education about the transition from an active lifestyle to a retired lifestyle.
- 400 Cheap health insurance. Registry of volunteer/part time activities.
- 402 1) Retirement locations. 2) Use of professional knowledge to serve others, and news about the need for such in this country.
- 403 Seminars on retirement. Seminars on retirement planning.

- 404 Open – send me more information to use the rest of my life. Productive for myself and family.
- 405 Work toward making malpractice insurance/benefits practical for doc in office 1 ½ - 2 days per week.
- 409 Transition already made.
- 411 Retirement plans.
- 419 Send money.
- 421 Address issues such as boredom, health, making a contribution to society, keeping up with medicine, ways to spend extra time, finding other interests, government impact on medicine, managed care issues, practice management issues.
- 425 Financial planning and management.
- 426 More information on locum tenens.
- 429 Group health plan.
- 430 Truly non-biased financial advice (written, seminars, Internet, etc.) I repeat, non-biased.
- 431 The many retirement workshops were of great value to me – in investing and thinking about what to do.
- 433 I'd be interested in hearing about opportunities for part-time work and volunteer situations in other parts of the world.
- 434 I have made the transition.
- 436 Health insurance to cover until Medicare.
- 437 Information.
- 438 Health insurance premiums for people under 65 years that are reasonable. Also dental insurance.
- 440 Medical insurance for family. Updates on improvements in medical science — less politics or billing issues. Info on opportunities to volunteer.
- 443 AAFP is doing a fine job – suggest only – effort to keep retired abreast of the times, help him continue in the “art” of the practice of medicine.
- 445 Help with finding places to volunteer “safe” from possibility of law suits or liability. Make continuing medical education available and reducing the costs for retirees.
- 447 Financial analysis without a hidden agenda to broker other pension plans.
- 449 Advice from those who retired and now regret it.
- 454 1) Retirement plans. 2) Locum tenens for retirees.
- 455 Articles on financial planning, i.e., compare various equity/estates to what to expect for retirement resources.
- 457 Financial advice to prepare for future.
- 460 Seminar.
- 461 Financial planning counseling services. Counseling regarding career changes.
- 462 An honorarium of between \$3,000 - \$5,000 per month.
- 464 To make available comments from doctors who have retired, what they are doing and how they are doing.
- 468 Journal articles or other publications on the issues and concerns. Please, no solicitations, hidden or overt. Full disclosure of any financial connections.
- 469 Health insurance – but you refused to cover me 20 years ago when I was a fellow.
- 471 Physician(s) to take over the office building and the practice.

- 472 Nothing more than currently. Continue to provide info re: current practice and general med community info.
- 474 Educate young physicians about needs when retired.
- 475 Medicare supplement insurance. Course on retirement planning.
- 476 Opportunities to serve in other parts of the world in family medicine – volunteer.
- 477 Opportunities for education. Financial planning.
- 479 Group health plan for family physicians.
- 480 *AFP* magazine.
- 481 Better financial advice.
- 485 Better protection of income for the solo doctor.
- 486 Long term care insurance.
- 491 Retirement planning seminars and materials.
- 492 Names and performance of retirement funds.
- 496 Journal articles, seminars, CME at state and national meetings on retirement options – both financial and actual activities/lifestyle.
- 497 Alternate practice opportunities – part time.
- 498 Financial fitness evaluation.
- 499 Keep me informed in changes of medicine.
- 500 Aid with part time or volunteer physician work in retirement, including appropriate licensure. I have many interests, but being a family physician and contributing member of society are certainly among them.
- 502 Researching and informing members of service opportunities, both in and out of medical practice.
- 503 Alternative income producing activities.
- 505 Pass legislation that would allow me to volunteer without paying malpractice insurance.
- 510 Employment networking.
- 511 Help us deliver better care without HMO. Majority of family physicians have sold out to HMO or HMO encourages more money for less work and care to patients.
- 514 Good IRA advice.
- 516 Free membership with full retirement. Reduced rates to attend CMEs.
- 517 I see many articles about preparing for retirement. I see NO articles for the already retired.
- 522 Have some influence on government/health (on management).
- 523 Consider establishing a corps of retired/semi-retired physicians to serve underserved populations here and abroad – deal with liability issues.
- 525 AAFP could provide investments, financial products and services to the members as a source of income should the need for premature retirement arise.
- 527 Supplemental health insurance – negotiate discounts that would truly benefit members, not just increase revenues.
- 529 List of other physicians retiring in the community – to foster camaraderie.
- 530 Advise doctors on a continuing basis how to begin preparing and to continue toward that goal.
- 531 Long term care insurance.
- 533 Good retirement planning.
- 535 Retirement is too far away for me to answer this question just yet.

- 536 Good journal and CME already available. I am an employee and have a retirement plan already.
- 542 I left before all the administrative hassle. I have never written prescriptions for narcotics for my family and I was very angry when the licensing board made prescription writing for anything for family illegal.
- 543 Bring me in to an environment where my experience and energy can contribute to the national good/good of the profession.
- 545 CME programs on retirement.
- 547 Separate the government from the practice of medicine.
- 548 CME programs.
- 549 Continue sending *American Family Physician* regularly.
- 550 1) Financial planning for retirement. 2) Listings of part-time job openings.
- 551 Savings plans from onset of practice.
- 552 Walk the walk of practicing physicians. Will every patient be downsized to LPN care because HMOs and Medicare don't consider paying a doctor worthwhile?
- 553 Make it easier to practice part time.
- 555 Health insurance for retired physicians.
- 556 More info on volunteer opportunities using one's existing organizational skills. Personally I am involved in volunteer activities outside of medicine.
- 557 Would like to be able to only partially retire, or rather work part-time, but current structure of medicine makes this very difficult.
- 562 1) Have a group of retired physicians who could give advise and counsel to future retirees. 2) Have a group of retirees who could coordinate voluntary services of those retirees who are willing to serve and unsure of their time to work for free, etc.
- 564 Possibly investment opportunities post retirement.
- 565 Continued efforts to teach practicing physicians about managed care. To list the things to do to prepare, e.g. notification of patients, other physicians; guidelines on dispersal of records; telling your staff, patients; transition what to do's.
- 568 Does a pretty good job now.
- 571 Long term care. Retirement newsletter with updates on politics and technology in summary.
- 575 Travel packages, CME.
- 576 Perhaps some continuation of receiving some of the AAFP's publications and any articles or information on "volunteerism" as a physician, etc.
- 577 Information on areas that would be interested in "part-time" doctors. Information on areas that doctors could volunteer their time and be free of a lot of "red tape" or "liability worries."
- 578 The ability to keep updated professionally and have some influence or voice in the direction medicine is taking – maintaining a license for limited practice.
- 579 Some articles on investing safely for retirement.
- 580 Offer more CME on retirement.
- 581 Sponsor symposium featuring small panel discussion of retirement issues.
- 582 Work with state chapters to institute legislation allowing retired physicians to staff "underinsured" free clinics.
- 589 Financial planning. Long term care.

- 590 Information on selling the practice. Retirement plans and long-term insurance.
591 A book of case histories showing how others have made satisfying transitions.
593 Recommendations for lawyer to deal with contract issues.
597 Keep up sending me the latest medical information.
598 Suggestions from those that have done it.
599 Give the results of this inquiry to future retirees.
600 Transition already completed 3 ½ years after retirement started. Now, main concerns include finances, health of self and wife.
604 Would like a source of volunteer needs.
605 Retirement planning. Living will. Annuity. Estate planning.
608 Sponsor a good Medigap insurance policy with pharmacy benefits.
609 All out effort to eliminate or reform managed care!
611 Developing a user-friendly plan for FPs to ease their way into volunteer medical work (e.g. third world) while still in practice, i.e. a chance to get their feet wet without too much of a financial commitment (this type of service is overdue).
613 Places and ways to give back by teaching courses, going for 1-2 weeks to underserved areas – volunteer to help learn/teach about new topics needed since 9/11, i.e. bio and chemical terrorism.
615 Available part-time employment.
616 Programs on retirement planning. Programs on how you can be retired and yet a useful contributor to community and medical education.
617 Retirement communities for FPs. Group tours for senior FPs and their families. Health insurance for 55-65 yr. old retired FPs and families.
621 Money management (financial planning). Time management.
622 Keep sending *AFP Journal*.
629 Medigap insurance.
630 Continue the journal – *American Family Practice*.
632 Directory of short-term volunteer opportunities, both in U.S. and overseas.
635 Opportunities to do volunteer work that would make a difference to society.
636 Organize a senior physician section of the academy (the Assoc. of Pediatrics has an active one).
642 CME on the net.
643 How to sell my practice.
644 Perhaps an article on how to deal with “half the salary and twice the wife.”
647 Guidelines on saving for retirement. Suggested books/readings on “how to” retire.
652 Part-time work placement site (online).
654 Help FPs unionize so there is money to retire to.
660 1) Ideas about free community service. 2) Health education programs, especially the preventive aspects to elementary, junior and high schools.
661 How to find a good fit to pass the practice to.
662 Would like to work overseas in Africa. Need as much info as possible re: Mediciens Sans Frontieres/other options.
663 I get more cost effective advice from people I can physically look at, locally.
664 Make CME meeting cheaper.
666 Have a list of places where an MD can contribute on a pro bono basis.
667 Check out (research) and recommend a good retirement software.

- 673 Keep up to date on practice of medicine. Physician financial news, especially retirement, investments and estate planning. Places family physicians as needed.
- 675 Part-time work, to be useful where are needs for my expertise.
- 679 Seminar on retirement issues.
- 680 Make known the availability of volunteer groups, i.e. Doctors without Borders, Habitat for Humanity, etc.
- 681 Provide information on retirement. Not stories on people with 2-3 million in assets.
- 682 1) Provide a highly respected retirement team to provide consistent return of my entire retirement funds or at least 50% of my retirement savings. 2) Provide cost effective retirement planning to reduce taxes on trusts and wills and keep them current with tax law changes.
- 685 Present choices of leisure activities. Help with decision of retirement income vs. cost of living.
- 686 This survey result. Estimates of income needed.
- 688 Need help to sell my office medical building and contents in Sedalia, MO, across the street from the only hospital in town (Bothwell Regional Health Center).
- 689 Give MDs over 65 a break and grant emeritus status for AAFP dues and board exams!
- 692 Reducing paperwork/managed care hassles.
- 694 Provide forum – local, national – if physicians wish to participate.
- 697 You seem to be doing it.
- 698 A meeting or “How To” booklet. A session at state AAFP meetings. Audio Digest, devote an issue to this. Health insurance.
- 704 When I do retire, I would like to know how best to proceed with my solo practice, i.e., selling the practice, transition of patients to a new MD, medical/legal implications, working part-time, etc.
- 705 Articles or information about medicine related opportunities to contribute after retirement.
- 707 Advanced education.
- 712 \$1,000,000 bucks (by return mail, please. Thanks!)
- 713 PR that encourages continued emotional commitment to the practice of medicine and health care to our society – no one else can.
- 714 None – I appreciate the “life” member status, allowing decreased expenses for continuing education.
- 715 Practice management seminars on computer or monographs – aggressive action to help physicians with insurance contract problems and reimbursement.
- 723 General policy of civil disobedience until all insurance companies go back to not for profit, or we get a deal like Microsoft.
- 726 Help to get tax breaks for home repair. Insurance for drug coverage.
- 727 Have information about what to expect in retirement. Sudden change, responsibilities to previous patients, family – can you write prescriptions? Legal and moral responsibilities – nowhere can you find these answers easily. Can I donate my time without fear of malpractice suits? I am still unclear about many issues – does my country need my services?

- 730 Provide information on starting a society/fellowship/organization of retired family physicians.
- 731 Perhaps similar to states certifying older persons into teaching; AAFP/ABFP/STFM could “certify” some of us for teaching. The age-old problem of melding town and gown.
- 732 Health care coverage.
- 733 I am fully retired in that I am not paid for my services. I donate my services, as medical director of our local “free” clinic, and must maintain my license to practice. As a retiree, I do not get notices of meetings, seem to have been dropped from mailing lists and I would like to come to a meeting again, maybe. Also as a retiree, with no related income, the cost of a meeting is not tax deductible. It would help to have access to meetings, preferable at a reduced rate, especially for those of us who continue as volunteers in our communities. I receive *AFP* and the monographs, which I use for CME. Once, when active, I received announcements of AAFP meetings, Virginia FP meetings and other local opportunities. Although I still receive announcements of WVFP meetings and state and local medical associations, I feel cut off as these are not very interesting. I might not go anyhow, but would like to feel I am still part of AAFP and entitled to come. Maybe we need a volunteer doctors’ group. Also, encourage our state chapters to help us more. I dropped my state membership because, as a volunteer, I could not pay the dues for local, state and national membership – so I seem to have lost my national membership too!
- 735 1) Help with health care – medication costs and affordable long term health care.
2) Would fight for universal health care.
- 741 If the role of gate keeper in managed care settings could be strengthened for the FP, then possibly part-time positions for senior physicians would become a reality.
- 743 Increased reimbursement.
- 748 No idea – I guess ways to calculate money needed to retire would help. Wonder if AAFP could be a clearing house for volunteer, locum tenens, free clinics, etc.
- 752 You have continued many services to me since my retirement, e.g., AFP, CME, and up-to-date info and articles on med, etc.
- 753 Post-retirement insurance and health insurance to supplement Medicare.
- 754 Legal aspects of retirement (i.e. records care, etc.)
- 759 In retiring, you don’t just walk away from the office. Know how to _____
_____ - insurance companies cost of – federal notification – hospital administrators, correspondence, magazines – tending record keepers etc.
- 771 Online chat room where retired sages offer advice. A winning lottery ticket. A travel chat room where folks can tell about the good and the bad aspects of places they visited. Or maybe an online travel log – send in a short bit on your travel and invite interested parties to e-mail you for more details. One more – a list of part-time jobs. Just a list of what semi-retired docs are doing to maintain some cash flow and still have time to enjoy the pursuit of hobbies, travel, etc.
- 772 Arrange for retired activities – both social and medical – community volunteer services.
- 775 Retirement plan and medical insurance.

- 776 I would like to hear what other doctors have done – retirement.
- 780 Non-sales conferences on estate planning, financial planning, long-term care insurance.
- 781 Advice, anecdotes from retired MDs.
- 782 Part-time practice – feasible?
- 783 No one (head hunters, academy of med, employment service) has been able to help me find: 1) conventional part-time wellness/prevention work (screening P.E.s, health education), or 2) unconventional health “edutainment” (I’m a singer/guitarist – I customize parody songs for medical organizations, pharmaceutical products, etc.) I would LOVE if the AAFP could establish centralized data banks to connect physicians with facilities needing part-time work, by specific categories (well exams/screening exams, urgent care, chart review) and more importantly, help us locate organizations/facilities that could utilize people with medical background for unusual work settings, e.g., MD to be on call for acute care for performing arts troupe; MD to write or collaborate on scripts for health education or edutainment programs for kids, teens and/or adults and seniors; MD to accompany wilderness travel expeditions (Gigi Hirsch, MD, started to provide such a service from her business in Boston, but then took another direction). Also, provide an affordable health insurance policy for those of us who have no other source (e.g., for group policies). I would be very interested in talking with someone at AAFP about working with the Academy myself to help create such innovative programs! (Health education/performing arts liaison.)
- 786 Educational program and material for retirement planning.
- 790 CME classes.
- 794 I had no problems, because I never was what I did.
- 797 Health insurance.
- 799 Courses on the economics of medicine. Investment issues.
- 800 An annual issue summarizing significant changes and new medicine or approaches to therapy to enable retired MDs to stay more current – geared toward retired MDs.
- 802 Review of long term health care.
- 804 Investment advice.
- 806 Recommending good retirement plans.
- 807 Advice for competing against HMO competition. Advice on contracts.
- 808 You have done nothing so far, why would you do anything now? You have allowed family practitioners to “die on the vine” by not setting forth ultimatums.
- 809 More input on retirement funds, investments.
- 813 Information about retirement planning (early in career).
- 817 Was a difficult problem, but a personal one.
- 818 Printed material regarding various retirement affairs.
- 823 Take my calls for the next 2 years.

6. What advice would you give to physicians who are considering retirement?

- 001 Don't until you can retire to something.
- 002 Save early and maximize before spending habits get too big.
- 003 Subscribe to intellectually challenging newspapers & magazines, e.g., NY Times, The Economist, Harpers, New Yorker, Scientific American. Maintain a regular exercise/outdoor recreational schedule. Keep out of your spouse's way.
- 005 Be sure that they have other interests. (Family – church – income – family visits)
- 006 Advise of options to complete retirement – volunteer positions, part-time positions, administrative jobs, i.e., to keep using medical talents and knowledge.
- 007 Plan ahead and do it.
- 008 Go slow – retire gradually. Increase interest in community activities. Teach – free.
- 009 Enjoy your family and friends. Improve your golf game if you enjoy playing. Give of yourself to church activities and worthwhile projects within your community.
- 012 Begin planning at age 40.
- 013 Save enough money for retirement.
- 015 Be ready to feel guilty (about not going to work) for 6 mo., then be ready to relax and enjoy life.
- 016 Have a hobby. Try music or art or golf! Take adult education courses, learn more about the computer. Keep in touch with your peers. Do occasional locum tenens. Exercise daily – walk the dog! Go to hospital CME courses.
- 018 Have financial security. Have other interests to pursue. Good relationship with spouse.
- 019 Start funding retirement plan early in career. Diversify investments. Seek expert advice from someone who doesn't profit from you.
- 020 Don't retire until you are certain of your decision.
- 021 Pay off mortgage. Get kids through college. Figure money needed for comfortable standard of living – have twice that in balanced investment plan – 30 years.
- 022 Become a volunteer and develop a hobby.
- 023 Retire when you feel you are financially sound. There are many things to do – also do volunteer work. I have been a full time county medical examiner.
- 027 Get good financial advice and management people in place at least several years in advance.
- 029 Consider medical insurance cards.
- 031 Don't.
- 032 Gradually slow down. Be sure of your future income.
- 033 Develop other interests.
- 034 Financial preparations. Emotional preparations. Physical preparations.
- 036 Enjoy it while you can.
- 037 Plan ahead for after retirement activities.
- 038 Develop other interests.
- 039 Start planning for your retirement at the beginning of your practice.

- 041 Initiate alternate plans in looking forward.
- 042 Everyone's needs are different, so I could not begin to give advice.
- 043 Plan on taxes. Remain friends with your patients. Donate time.
- 047 Work as long as you are able to.
- 048 Be prepared financially, spiritually and psychologically.
- 049 Stay involved.
- 050 If a retiree does not have something to do or plan to do, don't retire and keep as current as possible re: new techniques and info as possible.
- 051 Continue working as long as you enjoy it and you can still do a good job.
- 052 Number one – make sure you have enough money to live on until the end for yourself and wife. Keep making adjustments as necessary for yourself and your wife. Budget finances as necessary.
- 053 Develop a hobby, other interests. Consider city or local politics; do not become a couch potato. Golf, fishing, tennis, OE, but limit the physical activity to short time endeavors.
- 054 Be retired if you don't have better choice.
- 055 Prepare – have other interests or careers in mind, gradual phase-out of practice rather than sudden full retirement.
- 056 If you love medicine, do not ever totally quit what you do best.
- 057 Have goals and plans defined which will result in satisfying utilization of one's knowledge and experience.
- 058 To work long enough to avoid finance problems when having a long life.
- 059 Never put off until tomorrow what you can do today. More to life than medicine.
- 060 Do it quickly in 45 days or less.
- 061 Think twice prior to the final decision.
- 062 Prepare and plan to retire at least 2-3 yrs before you retire.
- 066 Make sure you have enough \$.
- 067 Don't do it if you have choice & meaningful employment.
- 069 Recognizing that the profession you entered no longer exists and move forward.
- 071 Work part-time 2-3x a week. 50% discount on medical insurance. ½ CME hours requirement. The same membership dues for AAFP & AMA.
- 072 Don't.
- 074 Do it.
- 075 Continue as long as possible.
- 076 Do what you want to do.
- 077 We need advice ourselves.
- 081 Don't. Work up part time at VA. Good way to keep up and slow down, plus get paid.
- 084 Develop their non-medical practice interests. Help the underdeveloped world with their healthcare needs.
- 086 Don't do things abruptly.
- 087 I'm still too far away (8 years) to really give advice.
- 089 Do not retire fully.
- 090 Stay active, volunteer; remember the "good times" when medicine was still rewarding to practice.
- 091 Prepare well in advance.

- 092 Go for it. Look forward to it. Bright future lies ahead. Pursue other goals of life. Spend time with family and travel a lot.
- 094 Have a plan.
- 095 Save early.
- 096 Change courses totally. There are many fields of endeavor both related to and unrelated to medical practice. “Hanging on” when one’s time has passed is bad medicine. Retirement is not the end.
- 097 You need to be prepared and have some orientation, such as reading, traveling, socializing with friends and enjoying more the family.
- 098 Keep mentally and physically active.
- 099 Do it!
- 100 Know details of buyout from your practice group. Consider costs after retirement such as medical. Plan how you will spend time in retirement – to be balanced, satisfied, and have a reason and purpose for living.
- 104 Be sure you would be happy retired and have alternative interests.
- 105 Have a life outside of medicine.
- 107 Develop other interests, now. Plan ahead.
- 108 Look for volunteer community work and hobbies to keep occupied.
- 110 Keep busy! Volunteer U.S. & other countries.
- 111 Work as long as it feels good and you have enough time to do everything you want.
- 113 Do what is best for patients.
- 114 Do it when you realize progress in medicine and young colleagues are running way ahead of you and you can’t keep up honestly. A former colleague is still at it at 83. Folks admire him but smile behind his back.
- 116 Don’t retire too soon, plan ahead, your patients will survive without you.
- 117 Continue to plan ahead.
- 118 Have some definite plans/interests. Give back to the community – volunteer.
- 119 Don’t rush it!
- 120 Do it.
- 121 Plan ahead.
- 122 If you are sound of mind and body, don’t do it. You can do so much!
- 123 Save, save, save. Set aside at least twice your annual income sufficient for you and your family to live on for a least 10 to 15 years and more if you are below 65 at retirement. No one can rely on the government to pay our social security benefits or medical expenses. You may wind up on welfare just as many who had good jobs just a few months ago.
- 126 Save money early. Keep busy. Try some part-time work. Charity work. TMA should cut dues for retired doctor members. This was tried before but failed.
- 128 Stay single. Save up for retirement before starting medical career.
- 130 Don’t – unless you have definite plans for you time.
- 131 Earn your _____ before retiring, don’t risk investments – steady but not spectacular, donate some time during retirement to some service group.
- 132 I haven’t done it yet!

- 134 Be sure to have an inside hobby and an outdoors hobby. Avoid being underfoot around your spouse. Take your spouse out often – movies, restaurants, theatres, etc. Have Fun!!
- 135 Don't put it off!
- 137 Start saving the day you open your office. Be home at 6:00 pm each day. Have a hobby.
- 139 Retire sooner if you can afford it, as practice stress and frustrations get worse each month.
- 140 Enjoy.
- 141 Don't.
- 142 Transition should not be abrupt. It should be gradual over a period of 2 years.
- 143 Plan for retirement early – save for retirement.
- 144 Save a lot.
- 145 Have plenty of cash set aside.
- 146 Keep active in your profession.
- 147 Make sure you have plans to occupy your mind and time when you do retire.
- 148 I was age 70 ½ upon retirement.
- 149 Have a life outside of medicine.
- 150 Save your money.
- 153 Keep enjoying what you do, while you are doing it.
- 154 Prepare about age 45 to 50 – get ready. Then do it. I started planning about 1957, increased preparation in 1978 and 1985. Retired 1994.
- 155 Keep busy, help the needy, find joy in serving others, encouraging others, especially young people and indigent patients who have been on alcohol and/or drugs.
- 158 Get involved in other activities.
- 159 Enjoy life, working or retired.
- 160 Keep up licenses. Attend med conferences and post grad studies. If possible, gradually cut down on hours over 2-4 years. Develop indoor and outdoor hobbies years before retirement.
- 162 Save and invest as early as possible.
- 163 Begin planning while young with identified goals – economic, social, family. Review periodically.
- 164 Retire as slowly as possible. Do not do a complete cutoff. Give patients adequate warning.
- 166 Start planning early.
- 167 Retirement planning – financial planning and saving.
- 169 Plan ahead. Retire gradually.
- 170 Find some interest to do.
- 171 Consider savings – attend the symposium on retirement and savings.
- 172 Have one or more pursuits to be interested and involved in.
- 174 Read the book “Halftime.”
- 175 Have sufficient other interests. (I do not.)
- 176 Refer patients to new physician of their choice at 18 mos. prior to retirement. Continued to follow patients until retirement. Patients did not feel abandoned.

- 178 Do it. Develop broad interests early in your career. Maintain physical fitness. Continue exercising your intellectual skills. Volunteer services.
- 179 Save money. Maintain good health. Keep in touch with professional activities.
- 180 Do it ASAP. Have a second interest.
- 185 Start planning and saving when you don't have the time or money for either one.
- 186 Save money. Invest money. Avoid credit card debts.
- 187 1) Be financially independent – if you don't know how, seek good source information. 2) Make every effort to have other interests – golf and fishing in my opinion, while time consuming, are not enough. 3) Pray for good health. This perhaps should be #1.
- 188 Work part time for a period of time – make a gradual transition.
- 189 Think about it a long time. Plan for it your whole career: time/\$/job.
- 191 Wise investments.
- 193 Plan for retirement and have a hobby or interest of some sort. Don't retire too young – medicine is the best way to spend your time. If you don't think so, why did you become a physician in the first place?
- 195 Maintain your health. Enjoy your family. Maintain your interest in medicine. Travel. Stay busy. Be active.
- 197 Keep up with journals. Keep outside interests.
- 198 Be prepared to live longer and be healthier than you thought. Make sure you have plenty of money. Be aware that medical practice is so much more fun as a volunteer or filling in at communities that are badly in need of physicians.
- 199 Do what you want to do, not what you've had to. If that includes work/part-time and that's what you want, do it.
- 200 Don't worry about keeping busy – there are plenty of things to do. Eat properly and exercise regularly.
- 201 Plan early. Learn to work less. Learn to live on 60-80K per year. Plan to work part-time to 70-75. Encourage the Academy to tailor the Board to what you actually do – not what you don't.
- 202 Don't.
- 203 Think twice.
- 205 If you have your house and car paid for and are debt-free and not a big spender, you don't need 75% of your present income to retire (I get along nicely on \$60,000 a year). Make sure you have interests and hobbies you and your wife enjoy doing together to keep life active and interesting.
- 207 I have just retired 3 mos. ago. Don't have enough time or experience to give any advice yet.
- 208 1) Consider all aspects of what you will face with retirement and time. 2) Start with semi or partial retirement and adjust your thinking and time use with this progressive experience. "Test the waters as you go!"
- 209 If you really enjoy practicing, do locum tenens.
- 212 Plan ahead – put money away early.
- 214 Begin to develop and focus leisure time on satisfying and mentally stimulating activities.
- 215 Do it. FP is boring.

- 216 Keep your registration of health permits. Volunteer – work even 10-14 days free care – ½ day of people without means of care. Health care network in Racine – problems treated by retired physicians of Racine County Wis. Outstanding program!
- 217 Begin planning early.
- 218 Don't wait until you get sick in order to retire. Enjoy life, family and the world at a time when you can do it physically, mentally and financially (but don't get greedy!)
- 219 Stay as active as possible both physically and mentally.
- 220 Retire to do something, not to do nothing.
- 222 Plan ahead!
- 223 Do it and enjoy it!
- 224 Keep busy, physically and mentally.
- 225 Make sure you have a life outside medicine.
- 227 Start funding retirement plan early.
- 228 Have a plan of what you want to do to fill your time in retirement.
- 229 Take time to serve (volunteer) and spend more time with family by traveling.
- 231 Be sure to have other interests.
- 232 Consider locum tenens for area MDs in some specialty to cover vacations, etc.
- 233 Retire.
- 234 Advise staying active in medicine in a reduced and less stressful capacity.
- 236 Financial protection for tomorrow.
- 238 Plan 2-3 years ahead.
- 239 Start planning for retirement several years in advance to insure adequate finances, and pursue some outside interest or hobby during practicing years.
- 243 Pursue other interests prior to retirement and follow the same after retirement.
- 244 Have interests other than medicine. Have a financial plan.
- 246 If you want to retire and can afford to do so, you should retire. Your patients will be taken care of.
- 249 Your patients may get better care after you retire – if you continue to practice too long.
- 250 Be sure you have hobbies to keep busy. Learn to help around home for a change. Enjoy yourself!
- 251 Select areas in your practice that you wish to continue; eliminate all headaches; schedule travel and fun and service while you continue to provide service to your community and others.
- 252 Good for them.
- 253 Do not only retire “from” medicine, but retire “to” something else. Accept change as stimulating.
- 254 Have an interest in which you will achieve – I started playing golf, reading anything and everything – mainly historical novels, follow stock market, physical fitness, much closer to wife and family, 3 kids, 7 grandchildren, one great grandchild (18 mos.) – have a new lease on life! And a greater interest in church life.
- 255 Find other interests to occupy your time. Keep active at something.
- 256 Start early planning, financial and mental.

- 258 Cultivate activities and interests (especially those that provide intellectual challenge) while still in active career, things that can be expanded when retired and provide primary satisfaction and sense of accomplishment to help maintain perception of self worth and to continue building. Be ready to spend more time with family than allotted during career.
- 259 Don't.
- 261 Do what you enjoy. Love your partner and family.
- 262 Have a second life.
- 263 Develop hobbies or interests other than medicine.
- 264 Do it earlier rather than later.
- 265 Have a plan/other things to do. Have fun! If not happy – do it now!
- 266 Volunteer medical opportunities.
- 267 1) If undecided, gradually limit practice. 2) If considering moving, spend some time in community, checking it out to be sure it will be satisfactory to meet your needs. 3) Look to the future, don't dwell on the past. 4) Be useful: home, community (volunteer, etc.).
- 268 Be sure to get involved in other interests – community, church, tennis, golf, travel, etc.
- 269 Develop hobbies now. Save up some money.
- 270 Go slow. Sell out to larger clinic or hospital or med care to get best price!
- 271 Continue practice, at least part time, if your health permits. The investment in training and practice is too great to retire completely, as nothing can replace the challenge and satisfaction of medical practice.
- 275 Plan ahead.
- 276 Put aside money just not for house expenses, but also for your pleasure – boat, trips (you have not taken). Keep up with new things in medicine or let it go!
- 278 1) Start planning at 35, not 65. 2) Learn financial facts such as asset allocation, compounding, diversification. 3) Learn new ways to structure time.
- 279 Plan ahead.
- 282 Everyone is different. Enjoy life! Thanks for your interest and concern!
- 283 Look for opportunities to serve underserved populations (e.g., volunteer to see poor patients for free, mission trips to developing countries). Develop another career. I'm thinking about teaching at a small college.
- 284 Quit when you no longer enjoy it. Do not give your license!
- 285 Do it when you're ready.
- 286 Review retirement funds. Discuss with family, especially spouse. Plan for future activities.
- 287 Plan.
- 288 Make plans for hobbies, travels to keep busy and try to keep active in medicine.
- 289 Hang in there while you still have a good bit to offer.
- 291 Make sure your egg basket is enough to carry you through retirement.
- 293 Think now about financial matters and developing other interests.
- 294 Plan for future contributions to society – I believe we should be needed and useful. Decide where you wish to live. Get your financial “ducks” in a row.
- 295 Don't.
- 296 Keep practice going as long as it is fun!

- 297 Keep busy at something.
- 298 Stop completely and all at once – do not “drag it out.” Go and do the things you like and always wanted to. “Don’t look back – something might be gaining on you.” – quote from Satchel Paige
- 300 Develop a hobby and ride it hard. Retire gradually. Develop affiliations with volunteer organizations. Develop computer skills – a great diversion. There are organizations which provide travel and educational courses throughout the world.
- 301 Should have other interests – or create them.
- 304 Pursue other aspects of life intensely – family, hobbies, community, church.
- 305 Do it! Make good investments. Enjoy life.
- 306 Do it before it’s too late.
- 307 When you think you are indispensable, get out. Please read my little book, “The making of a family physician.” I sent the book to FP.
- 308 Think twice.
- 309 Have broad interests, be frugal, don’t drink.
- 310 I am choosing to work part time to supplement my income and to keep involved in medical practice. At age 78, a part-time job suits my needs just fine. I won’t completely retire until my health requires it.
- 312 Haven’t retired yet.
- 316 Good financial planning. Develop a step wise plan for retirement that includes input from family and colleagues.
- 317 Have interests outside of medicine.
- 318 Have a life outside of medicine – I do!
- 319 Save more money to offset inflation.
- 320 1) Anticipate by at least one year. 2) Have a sound financial plan (should have started 20 - 30 years ago). 3) Have a hobby or plenty of things to do. 4) Keep active mind and body. 5) Indulge yourself!
- 321 Go for it.
- 322 Monitor investments.
- 323 The sooner the better!
- 324 Essential to have things you want to do – and not to retire just because of frustrations with changes that have occurred. I have been offered a position on a private institutional review board. It is immensely interesting and rewarding. I believe it is valuable for some MDs to find part time “medical” activities.
- 325 Be sure you have something to keep you busy. Stay involved with some kind of charitable service.
- 326 Retire before you are too old to travel. Do things that please you. Start working on health needs. Some doctors are not good patients.
- 327 Continue with your CMEs. Continue to be certified in CPR periodically. Be sure you have many interests to make life interesting.
- 328 1) Take advantage of Roth IRA. 2) Work as long as possible. 3) I found it difficult to partially retire.
- 329 Start planning for it when you start practice! It is more important than the simple financial planning so much is written about and journals devoted to. This is a field full of opportunity for the Academy to extend its concerns to the full spectrum of its membership. Our Academy has programs or links such as International Family

- Medicine, Heart to Heart International but these are not seeking to tap the resources of the senior physicians per se and are mostly focused on foreign needs. Participation in LOCAL community needs often is limited by lack of malpractice coverage. Perhaps the academy can help the semi retired physician be involved through some sort of innovative malpractice program that could increase his/her local community involvement. Please let me know how I can be of help. How about an Academy-related locum tenens panel?
- 330 Broaden your interests. Be active in whatever community you retire.
- 331 To be able to develop other interests besides medicine.
- 333 Enact plan now.
- 337 Consider office based practice part time.
- 338 It is best to retire to something – hobby, travel, more time with extended family, more time at the lake, etc.
- 339 The Practice of Medicine that most of us learned to love and be proud of is pretty much a left brained (problem solving) activity. Many of you will want to let your right brain explore using your time “creatively” (and you will probably be good at it!) Prepare for it a bit as you are moving in to retirement. (Art? Music? Sculpture? Writing? Gardening?) Enjoy! P.S. – also, if you are not physically fit, get that way! Work at it with a smile, daily!
- 340 Retire when you’re still healthy and in general good condition. Be financially secure and independent. There is good life after retirement – if you are healthy and financially comfortable.
- 343 Don’t just practice medicine – start early to develop outside interests – so you will have something to fill your time.
- 345 Develop productive interests outside of medicine which can progress in retirement. One can only golf so much and then not all year. Our athletic director gave us this advice when I was in high school. It makes sense and has worked well.
- 349 Be sure retirement is what you want. Maybe partially retire first – work in an area where you are really needed – like long term care, free clinics, etc. Stay involved in some way as a physician in the community. This is the MAIN thing!
- 352 Plan well ahead for financial freedom (aside from IRA, social security, etc.). Maintain interests and a healthy life outside medicine. Be humble – get off the pedestal willingly.
- 354 Start saving 20 years in advance.
- 355 Have other planned interests. Your biggest expense may be health insurance!
- 356 Don’t. Just slow down when you are “on top.”
- 357 Invest pretax dollars regularly. Cultivate some interests while still working. Don’t wait until your health has begun to fail.
- 359 Develop relationships outside medical activities: make a list of activities and interests you have not had time to pursue.
- 361 Don’t retire, at least not completely.
- 362 Think about it 20 years sooner than you think you’ll need it.
- 363 For those who have no interests outside of medicine, the adjustment can be traumatic. That M.D. is who we are, and one’s identity is suddenly altered. Mine

- is music. I play in two concert bands and have pursued music lessons. Find an interest outside of medicine.
- 365 Hang on until the bitter end because in this era of controlled physician fees and when PAs get paid more than MDs to see a Medicaid patient, no one else (AMA, etc) is willing to help or can help our profession! That's the TRUTH!
- 366 Don't – I practiced as long as my health allowed – enjoyed every day of it.
- 370 Pursue other interests other than medicine. Don't retire “partially” just do it!
- 371 Make sure you have something to retire to. If you like what you do, why stop (unless it's health reasons). Incidentally, I'm widowed (10 yrs) but have close family ties.
- 372 As long as you enjoy medicine and your patients – DON'T! You will miss it.
- 373 Plan a hobby; I should have continued to practice – stopped. Had major back surgery two times (unsuccessful). I would not have needed surgery.
- 374 What will you do with your spare time?
- 375 Don't wait too long.
- 378 Save earlier.
- 379 I live on an island where there is always something that needs you, and positioning yourself to be needed is most important not only in medicine but in retirement.
- 384 Seek part-time practice.
- 386 Pursue your hobbies. Volunteer for a charity or whatever organization. Go to nearby medical meetings if you want to keep in touch.
- 387 Have other interests before retirement. Practice as long as you still enjoy it, then quit. Get active in church, theater, community.
- 389 Be sure you have enough money to live the same and afford trips, cruises, etc. if you want to make them. Get some part time volunteer medical work to do before you retire.
- 392 Plan.
- 394 Start planning at 30.
- 395 Always have interests and activities and dreams outside of medicine.
- 396 A) Transition to administrative medicine. B) Get involved in local community affairs.
- 397 To be prepared for the changes that will be! Effect on lifestyle and activity – understand these effects. Educate yourself about retirement – the pitfalls and the positives. Understand probable changes of people and family addressing and treating you as a retiree.
- 401 Make certain that you have a plan to do something you enjoy and that it's constructive.
- 402 Use your knowledge to help the sick in your society by any way you can, if you can.
- 403 Plan well in advance.
- 404 Use time for self and family.
- 405 Plan well. Save early (well before even considering it).
- 408 Do it early enough to “live it up” in retirement.
- 409 Find a compatible second career including service to others that challenges capabilities.

- 410 Keep up interest in community, church, etc.
- 412 1) Take courses in finance and business. 2) Take a study and degrees in law.
These should be offered in medical school - early on.
- 415 Don't.
- 418 QUIT!
- 420 Have something to do. Consider staying out of the stock market.
- 422 Keep busy. I volunteer 1 day a week at a fee free clinic. I ride a bike 200 miles
per month. Play golf 2 days a week. Do my own yard work.
- 423 Talk to a financial planner early in the process.
- 425 Make sure you have your money in sound investments, e.g. good annuities in a
sound insurance company.
- 426 More advice on financial considerations in regard to retirement.
- 427 Get out ASAP.
- 429 Have options and other interests.
- 430 Understand money management yourself before you even think about it. Plan for
it for years – 20 or so financially and at least 5 or so otherwise.
- 431 Be sure that you can't stand working such as patient care. Funds are crucial. Place
to retire is important. Consider teaching at UAMs. I hated administrative
medicine and hospital administration.
- 432 Have someone to be interested in, socially, emotionally, and sexually without any
guilt feeling or payback needed. Have something to be challenged by daily.
- 433 Plan early!
- 434 Way in advance of retirement, start developing interests and/or hobbies that will
help fill the void left by retirement. Plan ahead. Don't wait until the last minute.
- 435 Develop interests in other areas.
- 436 Take better care of your health.
- 437 Planned it.
- 438 Diversify retirement moneys and use more than one financial planner.
- 439 Assess plans – don't wait if health is a concern.
- 440 Plan it and do it – the reduction in stress is wonderful – but the concern for those
colleagues still working is large, and also – who will take our places.
- 443 Remember you are retired. Attend local CMEs. Attend state, even national
conferences or conventions, keeping abreast of the art, not the technique, of
practice.
- 444 I wish I had partially retired with an associate or in a larger office clinic to reduce
overhead and then later fully retired.
- 445 Plan for activities that will keep you interested (traveling, sports, hobbies,
reading, volunteering, politics, etc.). Make sure your standard of living will be
acceptable to you once you retire. Note: I am pleased with my retirement.
- 448 Get out now before you get any crazier or poorer!
- 449 Find something else to do, have some goals of some kind. Do not stop working of
some kind as long as you are mentally and physically able to do something as a
stimulus for something else interesting to do.
- 450 First consider partial retirement.
- 451 Retire gradually if possible – slowing down, not all at once. You are easily
replaceable and the world will go on if you quit! Don't expect your wife to give

- up her activities now that you have more time around the house. Blend with her schedule. I don't play golf, but she always has, so I drive her golf cart whenever. Have already in place some hobbies – I do antique boats, old cars, Coast Guard Auxiliary and old outboard motors for many years. Common sense!
- 452 Start saving early. Diversify your investments.
- 454 Never retire fully, only retire partially.
- 456 Don't do it!
- 457 Don't retire to nothing – keep some work/business/meaningful work.
- 461 Plan for retirement in advance. Don't burn any bridges. Seek professional help with financial planning. Plan to stay involved through teaching, volunteer work, etc.
- 462 When your health or your family are adversely affected by the current level of involvement in medicine, it's time to assess your priorities.
- 464 Retire gradually (over few years cutting back hours). Have a plan.
- 466 Remain mentally and physically active. Volunteer.
- 467 Have other interests.
- 468 Don't – the world needs you. Transform your practice – drop out of managed care – refuse paperwork – cut costs and keep going. I have a home office now and a very small practice, and I love it!
- 470 Plan early – live on 60 percent of your post-tax dollars. Max out your 403b, 401k, 457b, 457f, IRA, spousal IRA, etc.
- 471 Enjoy life while you still can!
- 472 Start retirement plans early – develop diversified hobbies, interests and variable service projects.
- 474 1) Move from present location. 2) Keep up by CME. 3) Do some locum tenens to feel useful.
- 475 Keep active as long as possible.
- 477 Need to plan ahead.
- 478 Don't invest in Enron companies.
- 479 Plan early and save for retirement. Retire as early as you can. Cultivate interests through a lifetime.
- 480 Develop other interests!
- 481 Don't retire until you have to.
- 483 Find hobbies and organizations to keep you active – donating time and talent to assist church, community, etc.
- 485 Don't do it unless you have enough income to maintain your lifestyle.
- 486 Save!
- 487 Retire to something, not from something. Travel, garden, farm, etc.
- 489 Do retire while young enough to enjoy life.
- 490 Practice as long as it is fun and you can keep up.
- 491 Have activities available which are fulfilling enough to keep you interested and happy. (This has been true in my case.)
- 492 Put money away.
- 493 Retire as early as you can before you or your wife develops Alzheimer's. (My wife has had Alzheimer's for several years.)
- 495 Retire to and not just from – have a hobby or service to occupy your time.

- 496 Plan on activities, alternative jobs and interests to maintain involvement in life.
499 Plan ahead. Retire when in good health. Make sure that you have good planning and financially sound.
- 501 Make sure you really want to retire and have hobbies and plans to keep self busy so as not to become bored.
- 502 Keep alert and informed, ease into retirement by part time transition, continue medical associations, attend meetings.
- 503 Plan carefully to “cover your tail,” e.g. liability insurance, record storage and availability.
- 507 Start early and be consistent.
- 508 Get out as soon as you can.
- 509 Plan for a second career. Be sure of financial security.
- 510 Maintain equanimity.
- 511 It seems family physician members are helping HMO to make more money for their executives.
- 513 May consider partial retirement. A graduated malpractice premium would be helpful – e.g., if working 50% of the time, pay 50% of annual premium.
- 514 Don’t find someplace where you do just medicine not paper.
- 516 If you are to stop what you have been doing, plan a very active retirement program filled with plans that motivate your body and mind.
- 517 You must have other interests. You should involve yourself in satisfying community activities. Learn computers. Spend time with grandchildren. Things I found I could do: work with Habitat; joined bell choir in church; joined local organizations (library, art museum, historical society, hospital, garden club); started to play golf; manage a computer and surf the net; do my own gardening; showshoe; made effort to make new friends; travel a lot; baby sit grandkids as often as possible; and lots more! My practice was a success and so is my retirement!
- 520 In any area there are numerous opportunities to volunteer one’s services, whether in a medical or non-medical field. Volunteer! Keep busy! Exercise!
- 522 Ease out gradually – if you can afford the high ongoing costs.
- 523 Go into a specialty that pays enough to save lots for retirement!
- 524 Start planning financially early so there is enough to live on when retired.
- 525 While in practice, always keep your financial house in order despite your busy professional schedule.
- 526 Do it!
- 527 Get out if you can – life is too short to waste fighting with insurance companies and Medicare.
- 529 1) Get input from entire family. 2) Get involved in social activities in church, school, senior citizens place. 3) Give lectures on geriatric topics at senior citizen center. 4) Pro-active at AARP and Medicare.
- 530 Make sure you are on a sound financial basis to support your retirement.
- 531 Take up a new vocation.
- 532 Continue to work until you have a doctor to replace you and/or get to 70 years of age. Then quit anyway. Invest wisely if you wish to retire without worries.
- 533 Save in your younger years and enjoy life’s simple pleasures.

- 534 Consider all different issues before making a non-reversible move.
- 535 Stay involved, do volunteer work, enjoy yourself.
- 538 Think a lot about it, plan it and make sure you don't give up something which you enjoy doing without a good substitute activity.
- 539 Retire as soon as you are financially secure. I am now president of a charitable foundation with assets of 30+ million – act as chair to board of trustees at my church. I am also the treasurer. I am busy – doing interesting and hopefully helpful work. Love it.
- 542 I am somewhat bitter. Consequently, I shouldn't give any advice.
- 543 Continue to find ways to get someone to pay you to do what you want to do.
- 544 Fully fund your retirement plans and supplement with other funds when possible. Live somewhat below your means.
- 545 Plan ahead. Decide what you most want to do with your increased leisure time.
- 546 Keep working as long as it is satisfying.
- 547 Plan an early financial retirement arrangement. Have your family know about your retirement plans several years in advance.
- 548 Be sure of sufficient finances. Have at least two hobbies. Set up an exercise program at once and follow it. I am 81 years old.
- 549 1) Carefully consider the impact of suddenly stopping (changing) your fixed routine of many years (after merging my solo practice with a family practice group, I gradually tapered off my hours over 18 months). 2) Don't forget that, in most cases, your insurance "tail" prevents you from doing anything medical after retiring.
- 551 Start saving in the available plans early on! Incorporate if feasible.
- 552 Have a year's transition for patients and you to adjust.
- 555 Do it!
- 556 Develop other interests. There is a huge field of knowledge outside of medicine to explore!
- 558 Do it.
- 560 Develop other interests.
- 562 1) Plan ahead of your retirement date. 2) Be sure you have something to occupy your time.
- 563 If health and desire good enough, postpone beyond 70 – unless some compelling interest requires retirement.
- 564 Prepare.
- 565 1) Do not feel guilty. 2) While in active practice take time for self, institute hobbies, keep in touch with your family and friends. When you are off, turn your work button off. Have a place to get away (do not take work with you). Be sure you have competent, friendly physicians to substitute when away. Return favors to them bountifully. Make a schedule of needs: immediate notifications; dates can dispose of records; bundle – papers can be discarded by year. Keep a list of patients seen by you and where records go. Do not give original records to patients, offer to copy – if voluminous it is okay to charge. Keep record of where records went. Notify patients as far ahead as possible, but don't cut your trade off too soon. Put on records to keep the number of years your state laws will allow legal action (except children – also local state.) Provide a list of physicians but not

- a specific name. In my case, many patients wanted another woman. Also, insurance plans may have similar list. We all know the checker game of change in insurance plans. Only write or type in your record what you want known to anybody. Otherwise it is between the two of you.
- 566 If you like what you're doing and it makes you happy, keep working.
567 From the beginning, work for yourself and work early toward financial independence so that you can practice medicine in keeping with your own principles.
- 568 Plan for continuing in medicine to some degree.
569 Financial planning should begin early.
571 1) Buy more life insurance when young and long-term care. 2) Develop a second skill for retirement.
- 573 Have a good knowledge on how to handle your investments.
574 Probably the best way to retire is full retirement.
575 Find other interests, teaching, etc.
576 Plan ahead!
577 Have other interests besides medicine.
578 Stay involved – the younger liberal doctors will have medicine socialized (Hillary Care) incrementally UNLESS we do not allow it!
579 Do it, but be sure not as a result of an impulse.
580 Don't completely quit.
581 Better to retire too soon than too late (I learned this from a patient).
582 Starting planning from the first day of your career.
583 Get an hobby – keep part-time job as long as your mind is sharp. Those retirees who sit at home and watch TV do not last long. Couple years and they are gone (6 ft. under).
- 584 Begin your retirement savings at least 25 years before. Make use of every tax advantage to accomplish. Develop hobbies and other activities which you enjoy, long before retirement, especially those that benefit others.
585 Your wisdom and accumulated experience is acutely needed by younger physicians. Make yourself available in some way to them.
586 Reduce gradually the practice of medicine after you have saved enough money for future living.
587 Do it. Keep active mind. Protect health. Enjoy yourself and your wife.
588 Cultivate volunteer interests. Give self permission to enjoy.
589 To retire you have to plan for your health plan. And save enough money to retire.
590 Leave when you still can enjoy retirement.
591 Hone retirement skills well before retirement. Join one or more interest groups now.
- 593 Get out as soon as you can.
595 Plan ahead.
597 Keep up with medical information – go to your conventions (medical school). After your early several years of retirement, plan to find a retirement community to complete your life.
598 Make the decision yourself. I retired with no specific plans and have a full and enjoyable plate. There is more to life than medicine. I feel very fulfilled.

- 599 Do it.
- 600 Continue limited practice as long as fits acceptable needs for health, family, travel. Volunteering at health facilities can be rewarding. Also volunteering as mentor at school, etc. (in keeping with Pres. Bush's recent State of Union recommendations and Rotary International).
- 601 Have a part-time 2-3 day per week job. Save plenty of money first.
- 603 Have a passion for something. Right now, I have golf and dogs.
- 604 Each individual must make his or her own choices.
- 606 Establish a workable plan, execute that plan. Allow an adjustment period, then get on with the business of living.
- 608 Retire gradually if you can. Keep yourself busy with volunteer or part-time work. Have a hobby or a sport such as golf or tennis. Stay healthy.
- 609 If you enjoy medicine and can tolerate managed care, scale down and continue practicing until you exit feet first.
- 610 Put in your 30-40 years of a productive practice. That will leave a little time to enjoy the family and travel.
- 611 Develop other interests early that are expandable after retirement. Don't let concerns about boredom cause you to overload your early retirement schedule – you'll find there's plenty to do.
- 612 When no joy is derived, no pleasure found in medicine, and especially when you find yourself hating to go to work – it's time to get the hell out. That's what happened to me.
- 613 Don't worry – you will be fine and busy if you stay healthy.
- 614 Don't wait until you are 34 before starting college (Like I did!)
- 616 Good financial planning. Learn to live on a budget (I doubt many docs have lived on a budget during their active years). Spend part of your retirement in serving community needs.
- 617 Increase participation in civic activities. Practice preventative health. Work into it gradually, e.g. do some locum tenens work.
- 618 Keep your health up, otherwise you will have no retirement.
- 619 Do it slowly by stages.
- 620 If you have enough money to last you, retire and have some fun.
- 622 Develop hobbies and interests before retiring.
- 624 Do it.
- 625 Plan ahead. Develop hobbies/sports when young. Don't ruin your todays thinking about your tomorrows.
- 626 When you cannot give or want to give the time or energy needed, get out.
- 627 Be sure that it's what you want to do.
- 628 Don't! Try and cut back in total hours and increase your vacation time.
- 629 Haven't had enough experience yet to give advice, but they might test out their other interests, e.g., I went skiing for a month.
- 630 Do so. You will enjoy it.
- 632 Pay attention to your spouse!
- 633 Just do it.
- 634 Start saving early.
- 635 Continue to be active, even if it is not in a purely medical field.

- 636 As I have done, continue teaching and service to underprivileged. Stay active physically (I play tennis and workout in gym 3 times/week). Travel, attend cultural activities, read, participate in my hobby, photography (I have exhibited my photos) and follow my investments carefully on the Internet. I have no time to be bored. I wish there were more hours in the day to do all the things I want to do.
- 639 Buy Microsoft in 89 and sell it in 99 – keep interests outside of medicine – exercise, eat well, don't smoke or drink in excess. Stay healthy.
- 641 I retired because of medical problems, or else I would probably still be working. I always looked forward to retirement, but now am unable to do many things I would like to because of health reasons. Advise retire early at age 25.
- 642 Work hard. Get a good financial adviser and enjoy your family and medicine.
- 644 1) Start a pension plan early in practice. 2) Develop “outside” interests. 3) Learn how to deal with managed care and insurance companies without becoming frustrated. 4) Bring in a partner that your patients will like.
- 647 Lower your expectations and learn to live much more modestly (in terms of lifestyle). Cultivate many interests outside of medicine.
- 649 Find something to do.
- 651 Pursue more creative and less frustrating interests before you are unable to do so.
- 653 Work hard toward a good retirement program and retire as soon as you possibly can!
- 654 Look for non-patient care forms of income.
- 659 Try to remember why you became a doctor in the first place.
- 660 Plan activities to be done after retirement, including personal and community service, since while practicing we were not able to have time to educate our patients in prevention of diseases.
- 661 Be realistic. Develop outside interests. Spend time with family now - waiting to do it until you retire won't work.
- 663 Aim low.
- 664 Enjoy every minute of your practice. When medical practice isn't FUN, quit!
- 665 Stay busy – shift energies to another focus – an enjoyable one or ones.
- 666 Get a hobby, get more involved as a volunteer for church and community. Plan your week so you will be focused to do certain things at certain times (i.e. have a structured life).
- 667 Start saving early with a plan.
- 670 Have hobbies and physical activities (I have a tennis court and ski). Have some interests in the home – gardening, cooking, repairs. Compatible friends are important, too.
- 671 Have interests, hobbies, friends.
- 672 It was the best thing I ever did – second only to being able to practice medicine, which was the light of my life.
- 673 Stay involved; use your brain. I go to AAFP approved CME every week. Get physical exercise ½ - 1 hr daily. Enjoy your children and grandchildren. “You don't retire, you just don't get paid.” I call it pay back time. I last saw patients age 72 years – I miss them. At present I'm doing lots of medicine-related volunteering. I interview applicants for medical school and sit on admissions committee that meets every week. I sit on two hospitals board of directors; Health

- Alliance of CNY for health care delivery; board of directors of one nursing home; board of directors of Home Aids – non-profit co.; chairman QI/QA committee for Home Care Infusion nonprofit; board of trustees at church; admissions at community college; medical school clinical faculty. Many other people-involved activities, ex: retired programs.
- 675 Work as long as you can.
- 678 Plan ahead; fully fund retirement savings as early in your career as possible.
- 679 Do it! But have plans in place to fill this time – travel, etc.
- 680 Do it!
- 682 Don't keep all your money in a few investment options. Stay diversified!
- 683 Plan early for it! I believe the idea of practicing into your 70s is passé.
- 684 Make plans for retirement as you make plans to work. Medical “malpractice” insurance in Mississippi is outrageous.
- 685 If you can afford it, QUIT.
- 686 Begin to plan retirement first day of practice. Develop other interests; keep fit. Get professional financial management for retirement assets. Develop your spiritual life fully.
- 687 You will know when it's time to retire.
- 688 1) Sign up to work in a free clinic once or twice weekly. 2) When on vacation, see if you can help as a volunteer in a free clinic.
- 689 Plan ahead! Cultivate interests and hobbies all your life. Consider volunteer work in your community.
- 690 Partial retirement works great – whereas I've heard several other physicians who fully retired express some regret. I have found more than enough opportunities to continue to serve in our community, and made time for CMEs and did better on my boards this year than ever before. Plus my income from part-time work is much appreciated.
- 691 If you can, go for it!
- 693 Make sure you are prepared, mentally and financially.
- 694 Plan ahead. See investment planner.
- 698 Cut back slowly – go part-time as long as you can. Be sure to have lawyer lottery insurance.
- 700 Don't! Unless health is an issue – I can think of no good reason to retire, and yes, I am financially able to at any time.
- 704 If you are content with your practice, continue it or perhaps consider selling the practice and working part-time, etc.
- 706 Have plans and goals.
- 707 Stay active. Volunteer services for needy. Stay abreast of latest medical information.
- 709 Plan it well in advance.
- 711 Work as long as you can if self-employed.
- 712 Have hobbies and outside interests – do all the things you've dreamed about!
- 713 Try to be certain you mentally have fulfilled your medical goals, remembering you were given the opportunity over those not chosen for medicine to provide these services.

- 714 Find some part-time use for your knowledge and talent – keep your mind sharp. Say yes to volunteer opportunities.
- 717 Don't.
- 718 1) The various membership dues get even more expensive when you have only part-time income to offset cost. 2) Not always able to get group health benefits if partially retired.
- 719 Don't do it!
- 720 Phase out over 1-3 years to lessen psychological impact.
- 723 Congratulations on a successful career. Don't forget democracy needs you. We don't know when or if democracy will ever break out here in the U.S.
- 725 Plan early.
- 726 Consult a "dependable" tax and retirement person. Be sure about adequate financial support. Thanks for asking.
- 727 Retire.
- 729 Prepare.
- 730 Don't, until you can no longer contribute to the good of the profession!
- 733 Consider donating your services to your local clinic for the poor. It can be hard work, but often rewarding. Many states have special licenses for volunteers.
- 734 Work as long as you enjoy it and feel that you are contributing to society's health.
- 735 1) Start with a financial adviser in your 50s at least. 2) Make sure your pension continues with your spouse after your death. 3) Get a journal, like the "Lancet" for *AFP* to keep up with medical changes.
- 736 Plan for utilization of extra time. Consider self-esteem in arena out of office. Intellectual pursuits.
- 738 Prepare yourself years in advance, emotionally and psychologically.
- 741 1) Make sure financial underpinning is sound. 2) Try to have some part-time commitment to medicine, but I know that is harder if one has had independent practice.
- 742 Do what's best for them all around.
- 743 They are lucky people. Enjoy your free time.
- 744 Plan part-time work. Continue reading (medical) and meeting attendance.
- 748 Keep using your skills – serve others.
- 749 Have several hobbies. Plan enough money.
- 750 Be certain it is not for the wrong reasons, e.g., burn out.
- 751 Have lots of other activities.
- 752 Enjoy it. Keep busy. Keep in contact with medicine.
- 753 Consider partial retirement starting earlier and lasting longer.
- 755 Do as you truly desire.
- 759 Plan. Think about it, then plan the little expenses.
- 760 Be sure they have adequate financial resources.
- 763 Don't disturb your wife's routine – she was managing very well when you weren't around all the time. Volunteer in some activity that will benefit others.
- 765 Plan ahead and enjoy!
- 766 Work as long as you can.
- 768 Start a retirement plan as early as possible.
- 769 Be sure. Too many return back to practice of medicine.

- 771 Do what's right for you. Some may be happiest continuing in full-time practice, others (like me) see broader horizons. Plan to include a stepped up exercise program including strength and endurance training – it'll make you younger!
- 772 Don't.
- 774 Keep busy! FT/PT travel. Hobbies. Enjoy the good life!
- 775 Do it!
- 776 Be prepared to be a nobody.
- 777 Invest wisely.
- 780 1) Live within your means. 2) Continue to contribute to society – teach, volunteer. 3) Don't try to save money for the "children."
- 781 Have a sound financial plan. Go for it!
- 786 Prepare for retirement at least two years ahead.
- 787 I should have retired at age 60-65.
- 789 Think carefully about it.
- 793 Live within your means!
- 794 Plan ahead and get used to being you, not what you do.
- 795 Plan early and stick to plans. Get "good" advice, not just expensive advice.
- 798 Don't wait for retirement to have some time for yourself and family.
- 799 Start retirement savings early. Develop interests that can be sustained after retirement.
- 800 Start planning 10 years ahead to have some interest to retire to or you will turn into a vegetable.
- 801 Have other interests besides medicine. There is another life out there.
- 802 Careful planning.
- 803 If you are a physician contemplating retirement, I would recommend that you, first of all, thoroughly evaluate reasons for your present dissatisfaction with your professional work. Are the conditions causing you distress out of your control to change? Secondly, consider how the implications of your reduced earnings will affect you personally, as well as your family and future community responsibilities.
- 804 Protect your health.
- 808 Take business courses, quit wasting your time trying to make a living in medicine. Engineers, teachers and even garbage men in New York City earn a better wage than we do. Stop carrying the country on your back – free!
- 809 Keep other interests, even while working.
- 810 Don't.
- 812 Financial preparation.
- 817 As one retired doctor told me, "Don't retire."
- 819 Have enough saved that permits you to live on the interest and dividend income.
- 820 Do it if you have the money! As you read this, I am in the process of changing from FP to ER doc. My husband and I (also FP) have had NO INCOME (except for \$6800 before taxes in Nov. 2001) since 9/01 thanks to denials of legitimate claims by all insurers, increased overhead, increased workload at hospitals. Sadly, we will make enough money to retire much sooner working ER.
- 822 Establish a sound financial base on which to draw. Where possible – retire in surroundings compatible with your needs and comfort. If possible, eliminate the

possibility in the future of having to move at a less desirable time. Retiring in the community where Dr. Cole practiced for so many years has been a big plus.

823 If possible, transition slowly.