Retirement: A Personal Perspective of When, Why, and How

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ABSTRACT

Retirement from colon and rectal surgery is usually a personal decision. The details of when, why, and how are individually specific and are shaped by our life experience, desires, personal and family commitments, and financial considerations. The reflections of two respected senior colon and rectal surgeons are presented to delineate some of these aspects.

KEYWORDS: Retirement, practice limitations

Objectives: Upon completion of this article, the reader should be familiar with the nonfinancial aspects of retirement from colon and rectal surgery.

Harry T. Papaconstantinou, M.D.

For many young physicians, retirement goals are limited to financial planning and retirement accounts (e.g., 401K, 403b). As the years pass, we become consumed with our careers and assume that retirement is far in the future and will take care of itself. This cannot be farther from the truth. There are numerous resources from which we can get information on the financial aspects of retirement; however, the questions of when, why, and how are more individual specific and are shaped by our life experience, desires, personal and family commitments, and financial considerations. This article is intended not to be a reference for how to plan your retirement but rather a few narrative experiences of some of our more respected colleagues who have faced or are facing retirement. How, when, and why you choose to retire constitute a personal and individual event. It is our hope that the experiences presented in this article will help the reader begin to think about a comprehensive retirement plan that meets his or her goals that are beyond financial considerations. This

should start early in one's career and should be reevaluated on a regular basis.

Ernestine Hambrick, M.D.

To explain why I did what I did about "retirement" back in January 1998, it is necessary for me to take you back to 1992. That was the year my older, only brother died of metastatic sigmoid cancer. When he was diagnosed, 60% of his liver was already replaced. He appropriately, I believe, declined futile 5-fluorouracil (5FU) chemotherapy, which was all we had to offer back then.

After recovering from surgery, he was amazingly well for 15 months. During this time, he got his family and affairs in order. He was even able to make three cross-country trips in his beloved 18-wheeler to say goodbye to the scores of friends he had made over his many years as a professional truck driver. During the final 3 months of his life, he faced his rapidly deteriorating physical condition and obviously imminent death

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with courage, grace, and peace. When he died, just 2 months past his 55th birthday, I lost not only my brother but my good friend as well. You can imagine my frustration as I watched all of this unfold through the eyes of a colon and rectal surgeon, knowing there was nothing to be done to stop it.

The next year, 1993, the first report from the National Polyp Study was published. This was how my journey toward retirement and my new career began. For the first time, here was evidence that we could actually do something to prevent colorectal cancer (CRC) from ever getting started, much less killing people. The evidence was irrefutable. When you found and removed colorectal polyps, you reduced deaths from CRC by at least 70% and up to 90%.

The science had become unquestionable. We now knew how to prevent CRC. The problem was that awareness of this was almost nonexistent for most individuals and physicians alike. I decided I should, could, would do something about this. At some point, it came to be a “must do” for me. It took several years of additional scientific data for me ultimately to arrive at knowing, without any shadow of a doubt, that I had to do something about the needless dying from CRC. Then, I had to find someone to whom I was willing to relinquish my practice. There was no moment of blinding revelation, no sudden knowing, no appearing of an absolutely clear, future path. There surely had to have been a turning point, but I am not able to tell you when or where it happened. If I were to guess, I would say it was in Seattle.

I publicly declared my intentions at the American Society of Colon and Rectal Surgeons Membership Meeting in Seattle in 1996. This came only after years of wrestling with the personal impact of this totally life-altering decision. These deliberations were done almost exclusively within myself. Once I had made the decision, I went about telling my family, friends, patients, and colleagues that I was going to do this outrageous thing. I am quite certain that more than a few of them thought me totally off my rocker. Graciously, no one actually said that to me.

Before and after Seattle, the ideas that led to the creation of the STOP CRC Foundation were not all mine, nor did they mature and come to fruition in isolation. Suggestions were made by many like-minded folks who also had glimpsed the possibility of a world without CRC. Once they grasped the vision, they too developed a passion for eradicating CRC as a major cancer killer. Many of the most enthusiastic ones, but by no means all, became members of the board of trustees of the foundation. Even with this support as well as encouragement from so many others, it still felt like stepping off into the darkness of the unknown.

After 25 years in practice, I had developed a comfort zone in which I was functioning as a colon

and rectal surgeon. It was the most fulfilling life I could have possibly imagined. On the other hand, I knew absolutely nothing about creating and running a not-for-profit education foundation. Learning on the job would become the order of the day, every day. And the rest, as they say, is history.

Would I have chosen to “retire” like this, at the age of 57, had my brother not died of colon cancer? Impossible to say, but most probably not. I truly loved my life as a colon and rectal surgeon. I find it impossible to imagine anything short of the senseless, needless loss of my brother that would have filled me with sufficient passion to draw me away from that other life. My life with STOP has been challenging and rewarding far beyond my wildest imagination when the journey began. Retiring this way took a very large leap of faith and an unrelenting, all-pervasive passion. Would I do it all over again? You betcha.

Howard D. Robertson, M.D.

All of life has a beginning, a body, and an ending. Colon and rectal surgery careers are no different. They begin, develop into a body of service to our patients, and they end. This process is full of happiness, grief, sorrow, joy, regret, satisfaction, and anger with the only constant being change. Change in career status is easier if you have thought about it ahead of time. In the early 1980s, I was a new colon and rectal surgeon stationed at Keesler Air Force Base, where I practiced colon and rectal surgery and was program director for the general surgery program. I was fortunate to have Dr. Eugene Sullivan and Dr. Norman Nigro visit as “visiting firemen.” During these visits, we had the opportunity to talk about the “heart” of a colon and rectal surgeon. These talks have helped shape my thoughts concerning retirement. We talked about humility, compassion, consistency in purpose, and steadfastness during troublesome times. These basic characteristics make change exciting and not dreaded. Colon and rectal surgeons always try to do what is best for their patients. Sometimes this means gearing down or even stepping aside. We have learned well from shepherds of old who would pass on their skills to younger shepherds and then turn the care of the flock over at an appropriate point. The old shepherd could then stay near the sheep pen and help out or step away to give attention to other aspects of life he did not have time for while shepherding. The heart of a colon and rectal surgeon (humility, compassion, consistency in purpose, and steadfastness during troublesome times) is the same heart found in the shepherd and can be applied to all beginnings and endings. The decision to end a career or redirect a career is complicated and very personal. All careers will end, and the key question is when it is time to retire or redirect. This question is

answered only by asking and honestly answering a series of other questions.

1. *Have I stopped having "fun"?* Do I dread going to work? Do I find patients a burden? Do I enjoy my colleagues and coworkers?
2. *How much money do I really need versus how much money do I want?* What are my financial obligations (college, home, lifestyle)?
3. *Have I established a life to retire to or redirect toward?* When I do not go to work, where will I go and what will I do?
4. *Are my patient care abilities mentally and technically up to par?* Would my colleagues seek me out to care for them or their families?
5. *Do I have physical or emotional limitations?* Would continuing my pace cause me harm?
6. *What does my spouse think about this?*
7. *Have I accomplished my career goals?*
8. *Is there another colon and rectal surgeon available to care for my patients?*

When you have honestly answered these questions, you will have the answer to when you should retire or redirect your career. The answer I came up with was that it was time to redirect my career. I chose to limit my practice to anorectal surgery and colon cancer prevention. I guess I have decided to stay around the sheep pen and help out. Colon and rectal surgery grew out of a need for well-trained individuals who would devote their attention to diseases of the colon, rectum, and anus. Our present position as colon and rectal surgeons was born out of expertise in anorectal surgery. Our specialty lends itself to contraction of a practice to anorectal work. In fact, an anorectal surgeon with years of experience is indeed a valuable asset to a community. Limiting yourself to anorectal work can also allow more timely patient visits as well as decreased physical demands, such as long abdominal procedures and intense call schedules. A side benefit of limiting your practice to anorectal surgery is that it allows closer ongoing patient-physician relationships. Shifting to colon cancer prevention as a colon and rectal surgeon means shifting from taking care of one cancer at a time to preventing numerous cancers. This prevention can be one-on-one personal colonoscopy as well as teaching large groups of people about the need for colon cancer screening and prevention.

Humility comes in handy when you switch from doing it all to limiting your practice. A person who has created a haughty persona and ties his or her selfhood to this finds it difficult to be anything less. If you decide to limit or redirect your practice and you are within an organization, the next decision is whether to stay there or change location. Usually, this is answered

when you and your partners or group can agree on two items:

1. What patient service is needed that you can provide?
2. Are the finances acceptable; that is, will the institution and you each make sufficient funds to proceed with the service?

Even when you focus on the patient as the number one priority in deciding whether your new service is needed, it will be surprising how your new niche must not infringe on other colleagues within your department or institution. The finances may be easier than you think. I recommend that you come at the finances from a neutral standpoint. By neutral, I mean you should probably divest yourself from partnership status and not suggest there be a guaranteed minimal salary. This neutral standpoint shows that you really do want to invest your time and effort in a service you feel can benefit patients, your institution, and yourself. All three entities have to win. When everyone wins, it is easier to come up with an overhead percentage and a take-home percentage. This process will require compassion. As you start your new venture, always keep the patients' needs first. This attitude will help you be available to see that "add on" with rectal bleeding or anal pain. This consistency in purpose will be evident to your colleagues, patients, and coworkers. Purpose in life is very important—actions should reflect your purpose. The same steadfastness during troublesome times that got you through the difficult pelvic dissection or bleeding from the liver during hepatic resection for metastatic colon cancer will get you through the process of redirecting your practice. My advice to young colon and rectal surgeons is to develop the heart of a colon and rectal surgeon: humility, compassion, consistency in purpose, and steadfastness in troublesome times. This heart will embrace change, whether to end your colon and rectal practice, redirect your practice, or even redirect your life.

CONCLUSIONS

The editors would like to thank Drs. Robertson and Hambrick for sharing their personal experiences with retirement. These examples have shown how a career in colon and rectal surgery can be used to advance patient education and combat the major health problem of colon and rectal cancer. Dr. Hambrick has devoted the greater part of the last decade to developing and running the STOP Colon/Rectal Cancer Foundation. Dr. Robertson has redirected his career and practice to colon cancer prevention and the treatment of anorectal disease. Our advice to the reader is think about how, why, and when you wish to retire. If you know someone who has retired from medicine in

the capacity that you are interested in pursuing, talk to that person and discuss the benefits and potential pitfalls. Just as we read and prepare for every surgery we perform, it is important for us to prepare for the major life decision of retirement.

DISCLOSURE

Dr. Hambrick is the director of the STOP Colon/Rectal Cancer Foundation. The other authors have no conflicts to disclose with respect to this article.