COMMENTARY

Creative Retirement:
Beneficial for the Patient—What about the Doctor?

Ronald J. Manheimer, PhD

The term "creative retirement" may sound like just another of the many euphemisms and bits of marketing jargon that have accompanied the longevity revolution and simply a repackaging of the meaning of retirement. In one sense, it is. But in another sense, the capacity to imagine a "fresh map of life"[1] in the years that may follow partial or full withdrawal from a major occupation holds the potential for personal renewal. This can be achieved through redirecting a lifetime of knowledge, skills, and hard-earned wisdom into new fields of endeavor—whether for pay, on a volunteer basis, or simply for personal development.

One way to understand the term creative retirement is by analogy. From architecture and urban planning comes the concept of "adaptive reuse."[2] Turning vintage structures to new uses through modification and enhancement preserves a building's distinct beauty and integrity while giving it new vitality as part of the contemporary scene. Hence, long empty warehouses become condos, an abandoned power station becomes an art museum, and even outdated fire stations become restaurants and coffee houses. This principle of reinterpreting the function of an historical object parallels a person's reassessment of accumulated experience, life goals, and sense of purpose and meaning. Like any creative endeavor, the process is sometimes difficult—and this may be especially true for caregivers such as physicians.

Occupations that help to shape a person's sense of identity, calling, and self-worth are also ones from which it is difficult to disengage. The career of a physician requires extensive education, dedication, long hours, and considerable pressure. Once the letters MD have been added to your name, they remain there permanently. How and why, then, do medical doctors retire and what are the prospects for a creative next stage?

Bill Spinelli, a family practice physician who is part of a large medical group in a suburb of Minneapolis, puts it this way: "I like my stethoscope but hate the management."[3] Spinelli, 57, has researched the average retirement age of the approximately 500 doctors in his practice and that of other groups in the upper Midwest. "By 60, most of them are out," he says. Since the average retirement age in the United States is 63 and since medicine requires a longer investment of time, energy, and money than most careers while yielding considerable rewards in terms of monetary compensation, status, and tangible benefit to others, 60 is a relatively early age for withdrawal.

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"Not only is it early," says Spinelli, "their retirement represents a considerable loss to the profession and to the community." What are the forces compelling physicians to take down their shingles? "The burdens of the electronic environment, patients' demands, and the ever increasing amount of regulations and paperwork," says Spinelli. He is looking at these factors because Spinelli is embarking on a study funded by the Bush Foundation to better understand how doctors might be encouraged to remain longer in the medical field while finding ways to reactivate the idealism that attracted them to their calling in the first place. His own goal is to reduce the time he spends handling administrative matters and increase his opportunities for civic activism through teaching, mentoring at-risk youth, participating in free clinics, and through international medical work.

Spinelli's goal sounds like "adaptive reuse" in action. But does this model work for everyone?

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Marty Worthington,[a] a 64-year old gastroenterologist practicing in a medium-size medical group in California that he helped to found is also considering retirement—albeit, reluctantly. Over the last few years, following a mountain biking accident that partially damaged his right hand, Worthington has noticed a decline in his dexterity at conducting certain medical procedures. He has also become aware that in comparison to his younger colleagues, he lags behind in mastering the new database that has been brought into the practice. His colleagues assure him that he is well-appreciated by patients because of his caring bedside manner. Let an assistant deal with the database, they admonish. But the doctor has arrived at a different conclusion. "It's time to go," he says. The trouble is Worthington has few outside interests, his best friends are work-related, and he feels at a complete loss as to what he would do next.

Marty Worthington's decision may be described as an act of "moral obligation."[4] He recognizes that it is in the best interest of his patients that he step back to allow someone with a greater level of skill to carry on. He has been offered a form of compensation familiar in many clinical settings—an administrative post. But this is not enticing to him. Searching around and talking with other people in his situation, he has discovered several possibilities that hold some creative promise.

His list includes participating in a free medical clinic with flexible hours and initial training to familiarize him with current protocols for hypertension management and treatment of type 2 diabetes—chronic health problems somewhat distant from the work he has concentrated on for the past several decades. Working part-time at the clinic seems like a way to keep a hand in medicine and give back to his community, he says. The experience would also give him something to talk about at parties. Instead of answering the typical "What do you do?" with, "I'm retired," he can talk about the new patients and colleagues he's meeting as well as about the situation of the uninsured.

He's also learned about a Lifelong Learning Institute[b] connected with his local university. There he could sign up for noncredit courses taught by other retirees who do so on a volunteer basis. He's seen a catalog of courses that run from foreign languages to quantum mechanics. Exploring new learning options seems like a way to both discover new interests as well as meet interesting people—the latter valuable to Marty as a way to compensate for diminished workplace friendships. He could even teach something if he felt like it or possibly be a mentor in the premed program.

Another option is to segue into an "encore career,"[5] a vocation through which he might make good use of his medical training and research skills while adapting them to another field. Marty thinks he might like to become a high school biology teacher or teach part-time as an adjunct member of the faculty at the university. He's even considered going for an MBA and becoming a consultant for hospitals.

Physicians like Spinelli and Worthington would do well to follow these pathways to creative retirement since research on healthy aging points strongly to intellectual stimulation and social participation as key factors in both delaying the onset of dementia,[6] ameliorating depression triggered by isolation and inactivity,[7] staying cognitively fit,[8] and experiencing a higher quality of life.[9] Recent studies of retirement, even when controlling for preexisting medical conditions, also point to a correlation between early retirement and mortality rates.[10]

The so-called "new retirement" offers multiple pathways and choices. Doubtless, for physicians who attend to midlife adults, the topic of retirement has likely arisen, in part because of changes in insurance coverage but also in possible association with stress-related ailments. A thoughtful practice manager might put a few helpful books and magazines on how to pursue a creative retirement in the office waiting room.[c] The guy or gal with the stethoscope might also take a peek. **NCMJ**

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a Fictitious name used to protect confidentiality.

b For a list of Lifelong Learning Institutes, see http://www.elderhostel.org/EIN/intro.asp.

c For a list of helpful books on retirement, see http://www.unca.edu/ncccr/NewRetirement/RecommendedReadings.pdf.

REFERENCES

1 Laslett P. *A Fresh Map of Life: The Emergence of the Third Age.* Cambridge, MA: Harvard University Press; 1991.

2 Rebun J, Kelso R. *Building Evaluation for Adaptive Reuse and Preservation.* New York, NY: Wiley; 2008.

3 Spinelli W. Personal communication (telephone interview) August 3, 2008.

4 Manheimer R. The paradox of beneficial retirement: a journey into the vortex of nothingness. *JAHA.* 2008;2(2):84-98.

5 Freedman M. *Encore: Finding Work that Matters in the Second Half of Life.* New York, NY: Public Affairs; 2007.

6 Wilson RS, Scherr PA, Schneider JA, Tang Y, Bennett DA. Relation of cognitive activity to risk of developing Alzheimer disease. *Neurology.* 2007;69(20):1896-1897.

7 Rowe J, Kahn R. *Successful Aging: The MacArthur Foundation Study.* New York, NY: Pantheon; 1998.

8 Cohen GD, Perlstein S, Chapline J, et al. The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults 2 year results. *JAHA.* 2007;1(12):5-22.

9 Ryff CD. Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *J Pers Soc Psychol.* 1989;57(6):1069-1081.

10 Bamia C, Trichopoulou A, Trichopoulos D. Age at retirement and mortality in a general population sample. *Am J Epidemiol.* 2008;167(5):561-569.