My brush with (my own) death

Practising physicians realize more than most that people's lives can change in an instant. Accidents happen all the time to your patients—you just don't expect them to happen to you.

I remember the car hitting me but the rest is a bit foggy, which perhaps is a good thing. All I can say is thank goodness for helmets, as mine definitely saved my already underfunctioning brain—judging by the alteration in its former contour. My bike fared about the same, as, apparently, with enough force you can break a carbon frame in half. On the upside, I now have a new unicycle. Apart from my stable cervical spine fracture with secondary left upper-limb nerve damage, I came out much better. I was able to walk out of the hospital on my own steam, adorned by my new hard collar. I will sport this bold fashion statement (everyone is wearing one this season) for a month or so but I will heal in time.

I alternate between being thankful for being alive and not paralyzed, and feeling sorry for myself. My former life has temporarily been put on hold. I can't work and am not allowed to drive. And I can't swim, bike, or run. Sleeping is also a challenge. I have new appreciation for my patients who suffer from nerve pain. The best way to describe the zinging pain down my left arm into my numb fingers is that you can't get away from it. With a broken bone you can often find a position of comfort, but nerve pain follows you everywhere. I also have a new appreciation for narcotic-induced constipation.

We are all only an instant away from tragedy, so I challenge you to think about what you would do differently if you knew you were going to die soon.

Lying on the road, in the ambulance, and on the stretcher in the ER gave me time to think about what just happened and how close I came to leaving this planet. My heart goes out to those whose lives have changed without the hope of recovery. It is a sobering thought to consider how close to death or paralysis I was. We are all only an instant away from tragedy, so I challenge you to think about what you would do differently if you knew you were going to die soon. My list includes some of the items below:

- Embrace those whom you love and make sure they know it.
- Surround yourself with positive people who uplift you and inspire you to be a better person.
- Let go of all things negative as negativity is wasted energy and leads to nowhere good.
- Don't wait on your dreams.

I realize this editorial comes off a bit sappy, but it's not my fault as I recently faced death and have a head injury, so be patient with me. Lastly, remember what Ellen DeGeneres says at the end of each of her talk shows, "Be kind to one another."

—DRR

Retiring gracefully

If we are fortunate enough to live a long time, all of us must eventually retire. Even though a yearly RRSP contribution should remind us of that, reality doesn't usually strike until the first CPP cheque arrives. Few of us devote the same energy to an exit strategy from medicine as we did to getting started. Sure, there are many workdays when we wish for retirement, but in reality we mean an extended vacation rather than a terminal event.

Most of us are too busy to give the matter much thought; besides, who is going to look after all our patients?

Retirement brings changes in income, friendships, status, stimulation, and, perhaps most of all, one's sense of identity and purpose. Dr Alan Roadburg, in his book *Life After Medicine—Roadmap to Retirement Happiness*[1] describes the need to "re-tire" and find new stimulation and purpose when considering retirement. The development of a secondary career before retiring from medicine would, of course, obviate some of these concerns. However, if you are one of those few who could permanently live without an alarm clock, thrive under the monotonous sunshine of Palm Springs, and golf every day without having an existential meltdown, read no further.

Most physicians elect instead to ease into retirement rather than change careers. This strategy is easier for nonhospital-based physicians. The benefit of a gradual retirement strategy is that it provides for a less-precipitous decline in income and status and may also keep peace on the home front with a spouse unaccustomed to a daytime intruder.

Semiretirement does have some costs and commitment considerations. According to the College of Physicians and Surgeons of BC regulations, physicians must work at least 2 months per year in order to remain licensed. Moreover, the cost of CPD compliance, membership in the CFPC or RCPSC, CMPA, Doctors of BC, and College dues will erode the profitability of part-time work.

Not wishing to be encumbered by administrative and management obligations, many physicians will opt to work as a locum or in a walk-in clinic. This might seem like a good plan at first glance, but physicians should know their limits and be realistic about the neurocognitive decline that inevitably attends normal aging. Fluid cognitive abilities, which include analytic processes, spatial manipulation, and mental speed, peak in the third decade and decline more deeply in the seventh and eighth decades. Among the most important physiological changes are reduction in dexterity, short-term memory, problem solving, and the ability to adopt new ideas and critically examine old ones. Older physicians draw more on prior experience, relying on nonanalytic crystalized cognition. One of the hallmarks of age-related neurocognitive decline is "premature closure."[2]

> The interviews tended to be abrupt, with many interruptions, history taking was not comprehensive, data-gathering was incomplete, important management strategies were not considered and important details were left out of the patient records.

It is this that too often gets the older physician into trouble and triggers complaints from patients who are much less forgiving than those former patients with whom the physician had a long-term, caring relationship. In addition, high patient-volume situations, particularly prevalent in walk-in clinics, can quickly overwhelm the older physician accustomed to treating known patients at a comfortable pace.

A safer strategy for physicians contemplating semiretirement is to continue to care for familiar patients in a well-organized office with support from colleagues, patients, and staff. Even more so, working with younger physician colleagues can be invaluable.

Many older physicians may continue to practise safely in carefully selected settings that play to their strengths. At the same time, patients must be assured that physicians continue to practise competently, and this will result in increasing scrutiny of older physicians by medical regulatory authorities.

Retirement should be voluntary and planned. It is never too late to make retirement plans, even knowing that circumstances may change. A timely retirement, deliberately and thoughtfully managed with the best interests of patients given priority at every stage, is a professional obligation. For all of us, the reward for a successful end to a career in medicine should always be lifelong pride in our accomplishments.

—WRV

References

1. Roadburg A. Life after medicine: Roadmap to retirement happiness. Thornhill, ON: Second Career Program; 2005.
2. Eva KW. The aging physician: Changes in cognitive processing and their impact on medical practice. Acad Med 2002; 77:S1-6.