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EDITORIAL

WILEY

# Conversations in cardiology: Late career transitions—Retool, retire, refocus

In 1977, Andreas Gruentzig brought innovation through coronary balloon angioplasty and transformed medicine, impacting millions of patients and birthing a new medical subspecialty, Interventional Cardiology. The physicians in the inaugural class of PTCA are now 40 years older and are in late-career transitions moving to another version of their former life. Several years ago, Dr. Eric Bates from the University of Michigan in his requiem for an interventionalist[1] shared his wisdom for our younger colleagues on the traditions and good practices in the Cath lab that made life for us unique and for our patients, better. While these insights were inspiring, few expressed thoughts on how to make the transition from interventional cardiologist back to a mere mortal. It is with this background that this Conversation in Cardiology begins.

At the annual Scottsdale Interventional Forum meeting, hosted by Dr. David Rizik, Dr. Bob Applegate asked me about my retirement plans. I mentioned this to CCI Editor, Steve Bailey, who thought it would be good to understand how the late-career interventionalist is thinking.

Specifically, how does one manage the transition out of active practice without losing one's mind. Obviously, these questions pertain mostly to the senior interventionalists, but might be helpful to others in long-range planning as well. I asked my expert colleagues the following questions:

1. If you are thinking of retiring, what is your plan? Phase-out, like me going to 50% for a year then out? Go out cold turkey and move on? Move on to what? Can you provide your estimated time window (confidentially, of course), 1, 3, 5 years, and so on? It would be helpful for context.
2. Is there a role for the emeritus interventionalist at meetings? In the SCAI or TCT?
3. How do our industry partners view you? Should you care? Consultancies?
4. Should the SCAI play a bigger role in your transition? What resources or assistance might you need?

For full disclosure, my answers are not fully formed yet, but here they are. I'm going to 50%-time January 2023, moving out of the cath lab to consults and clinics, perhaps with some coverage of the cath lab until a new IC is on board. My free time will be filled with golf, cooking, family stuff, and industry, or other consulting (if they still want me) and some cardiology meeting attendance, but only if there's a role to fill. I think there is a role for the SCAI emeritus teachers, which would nicely meld the SCAI Masters and past Presidents with the ELMs or others needing mentoring.

Let's see what my colleagues said.

**Bonnie H. Weiner, Worchester, MA**: I don't know that I will ever retire in the traditional sense. There is no question that what I do has evolved over time. Some has been by choice, other because of circumstances. What is critical is making sure that whatever it is that you are doing (whether in or out of medicine) is satisfying and fulfilling. Everyone will have a different path.

There is no question that we still have things to offer both to practitioners and industry. We are often undervalued and/or disenfranchised locally, nationally, and internationally. Many of us have spent much of our careers involved with professional societies (SCAI in particular) or with industry partners. I don't think any of the societies have done a good job providing meaningful involvement as our careers have evolved. Paying lip service to us is not productive and isn't sufficient. I find that institutional memory is underutilized. I even see this in publications and manuscripts I review as topics that have been well studied seem to be revisited without new insights being provided. Yes, things change but if they haven't, why should we be repeating what we already know? The industry may just not know how to access us if we are less "present" clinically. A shame on their part since they are missing our perspectives and long view insights.

**Peter C. Block, Atlanta, GA**: As of 2017 I am "Emeritized" at Emory, though if people ask if I am retired, I usually respond with the truth—"well not entirely." COVID has accelerated this whole scenario since face-to-face meetings have been supplanted by Zoom. I realize I am at one end of the "retired" spectrum, but your questions beg for answers.

*If you are thinking of retiring, what is your plan?*It boils down to how one wants the departure from Cardiology to work. Some might just want to walk away, dropping their medical license and watching sunsets. That takes one day. No demerits in that. I decided that I still wanted to teach and be involved in research, thus I still work with the interventional fellows on mining the Emory database and writing papers. I find that when a journal asks me to review a submission, I spend more time and thought on that task and hope I, therefore, do a better, more balanced job. But don't fool yourself. Things move fast.

Knowledge/innovation is on a steep climb and the use of changing therapies as well as changing strategies is not a part-time job. When I proofread the pieces in the ACC's "CARDIOLOGY" that I coedit with John Harold, I marvel each month at the strides being described that I have missed. Could I go back to the clinic and

appropriately care for a patient with bad heart failure (e.g., knowing when to use, or the doses of sacubitril/valsartan or ivabradine, or omecamtiv mecarbil)? Not exactly! Yogi was wrong—when you come to a branch in the road—you can't take both. On the other hand, I have found things to keep me busy inside medicine, but none is where I can hurt a patient because of something I missed.

1. *Is there a role for the emeritus interventionalist at meetings? In the SCAI?*Someone said that experience is remembering all your mistakes. All Emerti have that to bring to the table. But to be honest, we are mostly decorative. Three years out of the lab makes you wonder what the next step in a discussion of a new procedure should be. How often can we talk about the history of PTCA! However, SCAI can be helpful in other ways. Once "Out" [retired], keeping current is an ongoing challenge. Being asked to review a submission becomes an honor rather than yet another task to get out of the way. Also, keep providing CME for these reviews and provide CME for web teaching, venues that might come through SCAI. CME is difficult to accumulate, and most license renewals ask for a substantial amount each year. SCAI could help make that easier!
2. *How do our industry partners view you? Should you care? Consultancies?*Honestly—if the industry can't use you for their bottom line, they will move on. I get that, and don't care. I do consult with a few defense law firms and enjoy the challenges defense work entails. But know that if patient care no longer is part of your day, your expertise (legally) disappears. My teaching overcomes that, but I can see that the end of that consulting is near.
3. *Should the SCAI play a bigger role in your transition?*What resources or assistance might you need? As I said above, CME through SCAI should be expanded. Not everyone is chosen to review a submission and receive CME from that, but access to teaching venues on the web could/should be a great asset both for SCAI and the Emeriti. If needed SCAI could charge for CME but making it a nominal charge and making it simple to claim and then collate would be an asset that would keep us all close to SCAI and vice versa.

Finally, ACC has an honorary emeritus status for retired members—no charge for ongoing membership. I still claim my MSCAI but am not sure I am still really a member. No loss to SCAI for doing the same as ACC and potentially keeping us closer to the Society and make attendance at the annual meeting more of a carrot for us.

**Mitchell Krucoff, Raleigh, NC**: When I turned 60 (8 years ago) I looked forward to 5-year blocks, and on the list of impact areas retirement certainly was one. A collective of like minded senior faculty, with younger faculty support, managed to abolish the Duke "rule of 70 years old" for mandatory retirement (as age discrimination), so at least I didn't have to do it just by the numbers. My primary driver is how long my personal health and technical skills will let me offer patients what I consider my best clinical/technical performance. As long as I feel I have something to offer patients and something to offer fellows and even faculty, I'll continue working since most of our current faculty, cath lab directors, and chiefs are those I trained as fellows.

I am not sure whether I will continue with clinical practice when my cath skills begin to erode. I enjoy covering CCU, fellows' clinics and consults, but not with the same passion I feel in the lab. The pandemic has been a big life lesson, on family time, and so on, on managing uncertainties and for now hold that part in limbo.

Independent of health, I am also very aware of the importance of giving rising young faculty time in the lab and cases to do, administrative challenges, and creating opportunities to support them in leading roles for research efforts. I feel moved sideways by this but still feel comfortable in being valued and respected for my views or my skills. Even now I really enjoy how much more I am progressively learning new things from the "young folks" I trained bring to the lab. What an amazing mix of established and rising stars.

The pandemic also erased my live teaching in cath labs overseas and the whole spectrum of Society meetings and workshops as international travel ceased. It was so definitive that I didn't go through a withdrawal syndrome; in fact, I quickly shifted to enjoying many weeks more time with children, grandchildren, my wife of 47 years, and long walks in Duke Forest with our dog… And I am not sure whether I will feel comfortable going into rural India or rural China in the next few months or even the next few years. I have not adapted to perpetual mask-wearing, and where trans-oceanic flights in the past were my sanctuary and respite, long flights wearing masks are not enjoyable.

Frankly, I don't see that SCAI or any scientific sessions have any special responsibility to the "senior" interventional class. This group has an incredible number of true pioneers and heroes. Senior interventionalists who can provide novel mentoring or didactic or research experiential value should be part of scientific sessions. But as a grandfather living through the pandemic, I am "all in" for ensuring that resources are focused as a priority on the young, rising interventionalists who are the future, especially where we have limited resources compared to prior eras.

**Christopher White, New Orleans, LA**: I'll chime in since I've got some direct experience with re-inventing my role. There are two obvious buckets. One, that doesn't apply to many, if any, on this list is the private practice guy, general cardiologist/interventionalist who has burned him/herself out with high volume clinical throughput, most of it not interventional, and is looking to get out as soon as they've made enough money to retire. I know one individual who was happy to quit at age 58. He hated his job.

For others, who find great purpose and satisfaction in cath lab work, we all should understand that a time will come when you physically just cannot maintain your mid-50s form. The question then is, do you exit medicine, or can you find purpose in other activities. Certainly teaching, mentoring, and coaching students, residents, fellows, and junior faculty are wonderful options if you can make that financially work.

I chose a different path. I changed careers as a senior respected clinician, and I have been able to build a bridge to engage our MDs in

making the inevitable transition from volume (productivity) to value (reducing waste, harm, and variation). Physicians are the "spenders" in our world. They order the tests and drugs and perform the procedures. There is a tremendous amount of waste, unnecessary procedures, and variation in clinical practice in our everyday practices, particularly in general/interventional cardiology. Hospitals and hospital systems know this, but traditional structures such as pharmacy, laboratory, and supply chain have been driven administratively and have tremendous difficulty in earning front-line physicians' trust and engagement.

This is the opportunity to evolve into that trusted source, who can be the bridge to the administrative professionals that identify opportunities for improvement. It is called "change management." Who better to make the argument that we can use any of several vendors DES for 90% of our work resulting in very significant cost savings for the organization. There is commoditization everywhere, but attempts to consolidate vendors for savings are met with physician preferences that defeat any attempt at vendor consolidation. Who better than us to make that argument? The same is true for difficult questions regarding high-cost drugs and laboratory overutilization. I've been in this role for a couple of years now and find it very rewarding and important work. For any who would like to talk more about it, I'm available.

**Carlos E. Ruiz, New York, NY**: Very interesting and important questions. I've always felt strongly about leaving the room for the new generations, to grow and bring innovations to the field as we did. Here are my two cents on your questions:

1. I thought long and hard for several years about how I was going to retire and decided to do it cold turkey. When the time came, after 2 extensions on my contract, and the COVID, I retired 100% from the cath lab. The past year I participated actively with the University by selecting SHD fellows and three times a week joining the MDT meeting, plus whenever they had difficult cases. I can only tell you that it has been mentally very tough for me. I still miss the cath lab and my patients the most, but we need to accept that our technical skills deteriorate with age, and the one that pays the price is the patient.
2. Emeritus status in my view can best provide support for the interventionalist only based on the memory of our experience, mostly of the disasters we encountered. Being open to challenging new and different approaches by the younger generation is the way to go. Meetings could be acceptable as long as we do not take the center stage and leave it for the younger ones. One option to explore could be to provide a live forum, one for coronary and another for structural, perhaps once a week by Zoom or equivalent media, to provide our expert opinion on whatever challenging cases they may have. SCAI would be the ideal house to set it up.
3. I think industry partners view us now with different glasses - they mostly look at their bottom line. I still consult for several industries, most of them startups, and I do enjoy that very much because it forces me to stay up to date to provide the right advice.

**Gregory Dehmer, Roanoke, VA**: Borrowing a phrase from a dear friend and fellow interventionist, I now refer to myself as a "recovering interventionist." For me and I as suspect for many others, being in the lab becomes part of who you are, and it is hard to recover from that. But it can be done. Both of our children are grown with their own families and have settled in the mid-Atlantic states (VA and NC). Sounds like Mitch and others have already learned that grandchildren change the equation, especially for our spouses' wives (in our family she is called Nana). Although I had a great job in Texas for 17 years, the pull of the grandchildren was overwhelming. After having great patience with all my cath lab time, late meals, missed band concerts, SCAI, ACC, and AHA meetings and being awakened by a blaring STEMI pager at 2 a.m., when my wife wanted to move East, it just seemed like the right thing to do. I got lucky and found a new role. It's a bit like what Chris White described as his new role at Ochsner. I work to coordinate and improve CV Quality and Outcomes in an 89-hospital system in southwest Virginia. I also staff with the fellows in the clinic one half-day most weeks. I feel as though I am making a difference and that's important to me.

For me this was an abrupt "cold turkey" change when we moved. Should one phase out or go cold turkey? I'm not sure there is a right answer for all individuals. However, I'm a firm believer that there is a volume-outcome relationship so if your volume is decreasing, I would always be asking myself if I'm as sharp as I should be? Complications will happen no matter how good or careful you are, so if your volume is 1/2 of what it was, any complication is twice as bad on your numbers. I always felt it was better to go out on top than have the fellows whispering in the background that "he's just is not as good as he once was." If you asked, do I miss the lab? My answer would be "every day." I miss the interaction with the fellows as much if not more than doing the procedures myself. I'll quit for good possibly in 2–3 years (age 75). However, you need a plan to keep busy. Just sitting on the sofa watching daytime television is not healthy. Golf is not my thing, but I have developed other hobbies that I never had enough time for in the past. It's very enjoyable.

Is there a role for the emeritus interventionist in SCAI? SCAI needs to be at the forefront of what is happening now and on the cutting edge of interventional therapies and I'm not sure we fit in that role. It's always fun to remind fellows that POBA actually did work, and we used 8 Fr catheters in the past, but beyond that, I'm not sure what our role should be. It's not SCAI's job to help us retire. COVID has crippled medical meetings for 2 years, but even before COVID, I found that I spent more time having coffee with old friends than at scientific sessions.

There is one question I would add. What about your Boards [M. K.—see answers below]? Not doing cases meant I could not "attest" to my caseload, so with sadness, I let my interventional boards lapse in 2019. I still have my cardiology boards and get MOC points for attending our local conferences, but now there is the ABIM Longitudinal Knowledge Assessment (LKA) and the ABIM/ACC Collaborative Maintenance Pathway. I still haven't figured these out and frankly, I'm not really interested. I wonder if AARP offers a Board Exam? (Figure 1).

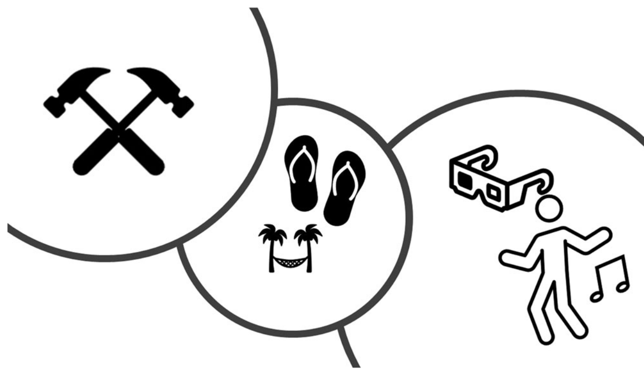

**FIGURE 1+** Options for late-career transitions: retool, retire, refocus—pick one.

**Lloyd W. Klein, Sonoma, CA**: I have been living in a transitional world for 3 years now. I sold my practices in Chicago a year before COVID started, which turned out to be a brilliant move on every level. My wife and I had been thinking about where we would go and settled on Sonoma County a few years prior. I am working a month per year at UCSF attending on the floors. I have written a number of papers that I always said I would write if I ever had time, and I have done that. I also did some moonlighting in a couple of rural cardiology clinics during COVID and enjoyed that very much. Outside of cardiology, I recently signed a book contract to write a book on the Civil War, which actually is already done. I have published now a number of history papers on that subject. And I bought a good backyard telescope when we moved here, and I am now in the Astronomical League, having become a decent intermediate level astronomer. We also spend a lot of time gardening, reading, and listening to all kinds of music obviously not in person lately, which is a big downer. For me, not being on STEMI call and not going to work 7 days a week was a fabulous move at a reasonable age.

My suggestions for transitions are (a) prolonged professional transition, (b) have a truly serious plan both for physical and cognitive activity, and (c) be sure you're financially prepared. It's a lot more expensive than you realize, especially medical and dental costs.

**John Bittl, Boston, MA**: On work effort: I believe that the answer to this question is practice-dependent. In academic medicine, there is a greater opportunity for going part-time, but in private practice, this may not be feasible or advisable. In my own situation, I announced my intention to retire at a group meeting 18 months before my retirement date and confirmed it 6 months before retirement. This time frame allowed my partners to recruit a replacement while I was still working 100%. A shorter notice would have made the transition more difficult for my partners. I retired completely from private practice on June 30, 2021, at the age of 68 after more than 5000 nights on call. I continue to volunteer for the American College of Cardiology and the American Heart Association on publication committees, editorial boards, and guideline writing committees, but I will phase this activity out over the next 12 to 24 months as my obligations expire and the ability to make relevant contributions diminishes.

On emeritus status: The short answer is yes. I will never forget the contributions that Spencer King has made at the meetings, particularly when he was editor of JACC interventions.

On consultancies with industry: Sorry, I have no expertise here. I've had no relations with the industry since going into private practice.

On SCAI help: SCAI and ACC have been wonderful, but I am not certain whether either society has the bandwidth to provide detailed retirement planning and financial advice.

On boards: I believe in lifelong learning, but I am not certain about the usefulness of formal board examinations for imminent, or immanent, retirees.

On a personal note: I would say that retirement has been an opportunity for me to repay my family for all the sacrifices they made for my career. The Nobel prize winner Kazuo Ishiguro said it best when he wrote in "*An Artist of the Floating World*" that, "For a couple, retirement is the best time of life." It has certainly been wonderful for us. My wife Jean and I sold our house in Ocala, Florida, on August 16, 2021, and moved back to New England to be closer to family. We split our time between our condominium at 23 Bay State Road in Boston and a beach house in Groton Long Point, Connecticut. Our daughter lives in Rhode Island, which is halfway between both locations and works in Providence as a special assistant Attorney General. Our son, who is in finance, and his family arrived from Hong Kong 4 weeks ago to escape the surge and now live with us at the beach house. Everyone is healthy. All of us have had a wonderful winter, exercising every day and sometimes going downhill skiing or iceskating, but going surfing as often as possible. A benefit of retirement has been the irreplaceable luxury of [more] time.

**Bob Applegate, Winston-Salem, NC**: I am retiring on June 30. This is a very personal and unique decision and will be different for each of us. My wife and I have been in a long-distance relationship for the past 9 years. For several reasons being together full time trumped all other desires. As I will be 70 1/2 in June, the timing seemed perfect to retire. Answers to the questions:

If you are thinking of retiring, what is your plan? I started thinking about this a few years ago, spurred on initially by health issues of several colleagues, and of my own, and I knew I wanted to be healthy and active in retirement. I have been 75% for the past 2 years and stopped STEMI call 3 years ago. This "Sunsetting" has been invaluable in terms of helping me sort through the emotions of contemplating giving up the cath lab at a time when I am still quite capable. It has also given me an opportunity to sample a more leisurely life and allow me the time to see if retirement would sit well with me and my wife. What I have learned is that our discipline is rigorous, and I need to be "all in" to function at the level I am accustomed to. When I retire, I will not seek part-time work, save volunteering at the local free clinic.

Is there a role for the emeritus interventionalist at meetings? There should be. My Dad was a business owner in Silicon Valley many years ago. He volunteered for an organization called SCORE (Service Corps of Retired Executives), which helped individuals interested in starting businesses, but needed advice. He received lots of gratification while helping a lot of young people. We could do the same through SCAI.

How do our industry partners view you? I'm neutral on this subject. It would be very beneficial to the industry to tap those with extensive experience, but I think younger docs should have access to industry processes to keep our field vibrant and contemporary.

Should the SCAI play a bigger role in your transition? I don't need help personally, but I think it would be useful to provide resources such as how to navigate medical insurance after retirement.

**Bonnie H. Weiner, Worchester, MA**: I must admit, I am more than a little saddened by this conversation. Don't get me wrong, I understand and respect every decision that we are making individually for our own reasons. I will however miss seeing many of you as friends as these transitions occur. What also saddens me is the loss of a unique group. We were the "founders and innovators" of a new and exciting segment of cardiology and medicine in general. None of our "younger selves" would have anticipated how much things have changed or the journey that got us here. I suspect a few of us still remember the days before CCUs existed and patients were in the hospital for weeks on bed rest after a STEMI for example. People with angina were told to take nitro and stop doing things. In my opinion, without us, our younger colleagues would not be having the opportunities they have, the industry would not be engaged in the same way, and structural heart interventions would not be evolving at the speed or effectiveness that they are. Seeing the loss of that "brain trust" saddens me. Yes, all things change, and we can't go on forever, but I do think we need to recognize and acknowledge what we may be losing. It may be inevitable, but I don't think I like it.

**David R. Holmes, Jr., Rochester, MN**: The American Surgical Societies have been concerned in this [retirement]. The ground in some ways has been explored by them. There was a Surgical Symposium on it several years ago. It drew a large audience. The panel included representatives of the Society, current and past Presidents, financial representatives, and a legal viewpoint. They defined the 4 D's of retirement in a specialty that defines itself by technical skill and procedural performance. The individuals in those societies like interventional cardiology define themselves by those criteria. The 4 D's were Depression, Divorce, Drug use, and Distilled Beverages. To those, you could add Death. The panel and symposium focused on those issues and found them to be a major and relatively common problem. Surgical Societies focus on these issues as should we.

**Sam Butman, Scottsdale, AZ**: I've been reading the posts with the attention you might expect from a 70-year-old.

Step 1: Realize you are not 40, 50, or 60 or so and remember what YOU thought then of an "elderly" interventional cardiologist's abilities.

Step 2: Review what David Holmes just summarized as the 4D's. So far, no Depression, no Divorce (except 30 years ago), or Drug use and the Distilled beverages are playing a very minor role and will not increase. I wish you the same. I will say that not missing the day-to-day grind has been a bit of a surprise, although I am doing occasional weekend locums, not so much for the money thankfully, but for the fact that I am worried I will not have enough to do. That does not seem to be a problem, so you are not likely to either.

What has helped me prepare for this was speaking to other retired people, primarily my patients, in the last few years and asking them about their retirement. Nothing better than being reassured you will be busy and that you will love being retired! They were correct.

**Jonathan M. Tobis, Santa Barbara, CA**: I have had a similar experience to those described above. I was very ambivalent about cutting back in the cath lab because I loved interventional cardiology and the procedures that we did. But some physical limitations and the recognition that time is running out made me decide to cut back. I no longer do coronary angioplasty, which has reduced the stress of doing those procedures. However, I still do PFO closures and occasional other procedures that other attendings are in the process of learning.

As to the psychological implications of retiring, I am constantly reminded of what my father said. He was a physician and noted that many of his physician friends who retired became depressed and felt that they were no longer relevant. He admonished me to continue working in some capacity. He transitioned from patient care to consultations, teaching residents, and doing committee work and became the chairman of the ethics committee at UC Irvine. He continued to do this until a month before he died at age 96. Taking this information from my favorite mentor, I am still seeing patients, although I am also playing more tennis and have become a gentleman farmer with fruit trees and beehives to care for.

I believe that SCAI can play a significant role in this transition. There could be a session for those who are interested in concerns related to retiring. There was a similar session at TCT several years ago, which I found very helpful. Just having the support of our colleagues would be useful.

**Carl Tommaso, Dallas, TX**: Someone once told me that since retired people get old quickly, so you should never retire, but move to a new "profession." Often this new profession is a continuation or expansion of a hobby or side gig that you had developed during practice, such as gardening, painting, writing, and so on. Unfortunately, some of us have been so focused on the practice of medicine that we never developed a side gig and that would make retirement empty. As many of you, know I retired "cold-turkey" and I knew it was time because my "hobby" was becoming increasingly important in my life. I moved to Texas, and though doing occasional locum, am very happy.

I have also experienced PTSD-like symptoms. One evening while sitting on my porch, someone walked by, and their pager went off. I had that moment of panic and surrealism that I am sure those with real PTSD have frequently. That episode made me realize that although at some point in my life I relished the "rush" of being paged, I realize now that I don't miss it, particularly the STEMI at 2:30 in the morning.

**Spencer King, Atlanta, GA**: This pandemic sure has changed us. I am sure we would not have been so philosophical in the past. I was reminded of how much I missed live meetings and seeing all of you when Ron Waksman involved me in the CRT in DC. Maybe the ACC and SCAI will also help us reconnect. But this "social time out" has produced some interesting reflection. I was lucky to remain engaged at Emory and other Atlanta health systems after deciding not to become a low volume operator. Working with fellows and faculty and participating in some research activities has been satisfying. One of

my current interests is disparities in care delivery through involvement with the New York State Cardiac Advisory Committee and my undergraduate university, Mercer University, which has three Medical Schools in Georgia. Rural healthcare is a mess. Could CTA become the diagnostic method of choice for coronary artery disease and be located to be easily available to all patients? If so, maybe some of us who have spent our whole life staring at coronary arteries could be useful in interpreting coronary CTA's, alongside of AI and whatever other automated technologies come along? Could we be worse at this than retired radiologists?

**Michael Kutcher, Winston-Salem, NC**: I usually refrain from discussing issues of age or retirement. But I am touched by all the thoughtful responses and have decided to contribute my own thoughts. Ironically, Bob Applegate and I will be retiring from full-time faculty at Wake Forest University School of Medicine at the same time—June 30 of this year. To your questions,

1. Retirement plan? I decided on a gradual transition over 5 years. In July 2017, at the age of 68 years, I proactively dropped out of STEMI call and the regular cath lab rotation. I didn't feel it was fair to younger faculty for me to take easier day cases and not night call. I continued as full-time clinical faculty for in-patient service. I increased my outpatient clinic time and continued as director of our Cardiovascular Information Services. I agreed, however, that if needed and if asked, to "pinch hit" in the cath/PCI lab to cover faculty time off for vacation, meetings, or sickness as our interventional team was overstretched at the time. I averaged about 100 cases cath/PCI per year for the next 2 years. In July of 2019, at the age of 70 years, I decided to totally leave the cath lab, as we had more faculty, and the number of cases was now less for me to continue at a high skill level. Mid-2019 to mid-2021, I continued full time in inpatient and outpatient clinics, teaching, and QI evaluations. Mid-2021 to the present, I halved my in patient service and outpatient clinic and continued teaching and QI endeavors—in particular, helping in our merger with Atrium Health. I will retire from full-time faculty and direct patient care on June 30, 2022, at the age of 73. Following that, I will be an Emeritus Professor at WFUSM and will continue to periodically help in QI endeavors, lectures, and teaching—but no direct patient care. I feel it is important to maintain some base camp with cardiovascular medicine.
2. Is there a role for the emeritus interventionalist at meetings? Yes. It is important to be available to provide input to our societies as to how one can transition, still be meaningful to our profession, and serve as positive examples for our younger colleagues.
3. How do our industry partners view you? I do not see a major role in the industry. This is for those active in the cath lab. Consultancies could be an option if requested for specific input from an experienced standpoint.
4. Should the SCAI play a bigger role in your transition? No. Transition is up to the individual.
5. Final points: As you plan and transition, have a dialog and at least semi-yearly meetings with your practice group head or academic chief or colleagues to discuss your goals and how the process is going. Dr. David Zhao, our Cardiovascular Medicine chief, was great to work with and very supportive. You owe it to your colleagues to let them know your intentions so they can plan for the future of the interventional team. One must concentrate on a variety of nonmedical interests now that one will have more time. I do not like the term "retirement," my wife and I agree that a better term is a "refocus" of life. [M. K.—I once suggested interventionalists should retool or retire, but you said it better, refocus]

**Tim Henry, Cincinnati, OH**: I am reading with interest the important reflections from people I love, and respect and I know these decisions are sooner than later for me as well! From an SCAI perspective, this is an extremely important issue. George Vetrovec has been spearheading an effort to send out a late-career survey on behalf of ACC Interventional council and SCAI with hopes to present results at the annual meeting. I will mention the insights from this "Conversations with Mort" on our next SCAI exec meeting call. A previous "Conversation" led to an official SCAI task force to investigate and provide recommendations for an IC fellowship match.

**John Hirshfeld, Philadelphia, PA**: I appreciate and respect all the wise comments, each of which has something to teach us about a facet of this multidimensional issue from experienced colleagues. I offer a couple of additional observations:

I worked in the cath lab until age 75. Penn gave me a terrific glide path going down gradually over a 7-year period to 50% effort in my last year. If you like your work and are not eager to quit, this sort of glide path is a Godsend. For me, the reduction was commensurate with the evolution of my stamina. I stopped overnight STEMI call at age 72. On my last day at work, I cath'ed the entire day. It was my preference as to how I wanted to go out.

During my glide path, I voluntarily and deliberately curtailed the complexity of procedures that I did. Because of the potential that I might not recognize developing deficiencies, I created an arrangement with Howie Herrmann that he would keep an eye on me and intervene if he thought it appropriate. I encourage you to have a younger respected colleague as a confederate.

In retirement, I have focused on fostering my medical knowledge so as not to lose it. This is my personal choice. It will not resonate with all retiring physicians, but for me, it has worked well. I continue to teach actively and, thanks to Zoom, can attend all the Cath Group conferences (in my pajamas). I accept every manuscript review request. I view them as an opportunity to learn and I have the time to put a robust effort into the review. I also took the opportunity presented by COVID to learn a ton about virology, immunology, and vaccinology.

I was concerned that I would miss the gratification of patient care. However, I found that the release from the pressures of patient responsibility nicely offset the loss of gratification.

When in the calendar year you retire can have substantial financial implications: It's best to retire at the beginning of the calendar year. The IRS requires that you take your first required

minimum distribution (RMD) from your retirement accounts during the year that you retire, and you must pay taxes on that income. The IRS definition of retirement is when your paycheck stops. If you have been prudent about contributing to your retirement accounts over your working career, your RMD may be a lot of money. Thus, if you retire in the middle or later of a calendar year, you will have a tax liability for both substantial salary income and a full year's worth of RMD. The result will be a tax bath for that year. Thus, it's better to have little or no salary income in your retirement year so your taxable income for that year is predominantly your RMD. A lot of people in academic jobs retire at the end of the academic year. Not the best plan as you will have had 6 months of salary and your RMD to pay taxes on. Also, if you are in good health, delay your Social Security to age 70. If you do that, the break-even point is age 78 and after that year you are progressively more and more ahead of the game.

**Srihari S. Naidu, Wintrop, NY**: I completely agree SCAI should find a way to harness the immense talent and experience of this "first generation" that birthed our field. I would also love to see how a formal role in the ELM program could be worked out. Those individuals would gain so much from all of you in innumerable ways.

**James Blankenship, Albuquerque, NM**: Interventionalists establish their careers in their 30s, physically peak in their 40s, mentally peak in their 50s, and experientially peak in their 60s. It seems from the responses so far that academic interventionalists retire between 65 and 75, before skills significantly deteriorate, while they still have excellent judgement, and experience that is unparalleled. I am at the front end of this "decade of [possible] retirement." The experiences of you who have gone before are instructive as I try to chart out these next years.

Mary and I have already followed the example of Greg Dehmer. When our grandchildren settled in New Mexico, we left friends and a satisfying 31-year career in Pennsylvania to start over in Albuquerque. While not easy, it was absolutely the best choice. Our only dilemma is what to do when our two sons on the East Coast start to procreate.

I often think of a comment made by a colleague here: "Your last intervention should be your best." Leave at your peak; empower someone to tell you when that is, as John Hirshfeld did. Another colleague commented that while they were no longer performing the most adventurous and cutting-edge procedures, they performed a valuable service by taking extra time to teach junior fellows the fundamentals of catheterization and intervention. As senior physicians, we may feel less hurried, and thus more willing to take extra time to coach our fellows through difficult procedures. When I let a junior fellow pass a stent to an easy type A lesion, it takes a little longer but their enthusiasm is palpable. It has taken a career for me to learn how to slow down and effectively teach the fundamentals of our trade, but our fellows appreciate it.

Similarly, as senior physicians, we may have more time to help medical students, residents, and fellows with the research projects that will help them attain their professional goals. Younger physicians, intent on their own careers, may not be quite as willing or motivated to do this. Working with these up-and-coming physicians not only helps them, but is fun for us and can start relationships that last for decades. Part of a transition to retirement can be to spend more time mentoring.

Young children watch and mimic their parents. Our adult children still watch us see how we navigate the challenges of life. In a similar way, our younger colleagues are watching us see how we navigate careers. I have watched many on this email chain to see how you manage these transitions. I am grateful to everyone who has shared their stories, and I will be watching to see how your strategies turn out, always eager to learn from you to transition into the next stage in my own career.

**Aaron Kaplan, Dartmouth, NH**: As someone who is in his final innings it has been interesting/helpful to read this conversation. I would like to share some specific thoughts about consulting. The perspective of a clinician with deep experience in the cath lab can contribute in many ways to the clinical development process. Two that come to mind: (1) Clinical Events Committees adjudicating adverse events. If this is of interest would reach out directly to the large Research Groups, for example, DCRI/Duke, Baim Institute-HCRI/Harvard, CRF, Yale, and so on and (2) teaching/proctoring the use of a new device. This requires the willingness and ability to travel regularly often to out of the way places. If interested would reach out directly to the specific company developing the product of interest.

**Augusto Pichard, Washington, DC**: This is my perspective. I am 76 years old. I stopped doing procedures at 72 (I did about 1000 procedures a year for decades). I joined Abbott Structural Heart as Medical Global Director for TAVR in 2017 until I retired from it in July 2021. I still participate in occasional consulting work: proctoring for TAVR, consulting in TAVR. This is my message:

1. Life is beautiful and plentiful outside of the Cath Lab. Do not be "afraid" of the transition!
2. Leave the Cath lab at your peak! Do not continue doing "simpler procedures": If you are not fully into it, you are not a true expert. Patients should get true experts taking care of them. Teach the younger generation this concept.
3. Most happiness comes out of providing "SERVICE TO OTHERS." This is what we did in our active life in the Hospital. The satisfaction was to CURE a patient, not to put a stent! This could now be volunteer work in the Hospital/University as mentioned by others, participation in panels/committees, and/or volunteer work in the community (there are innumerable exciting opportunities). Of course, we can contribute with our experience to Organizations (like SCAI, but not limited to it).
4. Most of us did not have enough time for the family during our active life in the Cath Lab. I am now carpooling for my grandchildren. It gives me lots of happiness and satisfaction. I am fully available to our 4 children and grandchildren to help with their complicated lives.
5. I get the greatest satisfaction seeing my colleagues/successors taking great care of patients including many of my prior patients. I occasionally join them in the Cath Lab as an observer. I still attend the weekly Cath Conference (Zoom).
6. I continue reading our Journals and stay up to date. I do read faster than before, and do not dwell on details.
7. While I am consulting, I still attend TCT, London Valves, CRT and will go to TVT and PCR (no Faculty role).

8. I have joined a book club, meditation group, energy healing group, and a walking group. I walk about 5 miles a day and enjoy staying in good shape.
9. I am going to write simple memoirs of my personal life to leave as a record for descendants to refer to in case any of them become curious/interested in it. I have learnt that each of us has a strong influence on our makeup from our ancestors, and I now realize, I have no info on most of my own ancestors.

**Kirk Garratt, Wilmington, DE**: Reading through this, I'm struck by a few themes.

Happiness comes with a good plan. The plan could have lots of different stuff in it. But you need a plan. A routine that requires effort and some degree of discipline will help. Interventionalists' thinking is too structured to thrive in an unstructured environment.

Timing matters. Whether you leave at your peak or a little after doesn't matter much, but for sure you don't want to be told it's time to go. Service to others is so foundational to our life's work that most of us will miss that much more than the technical stuff. Find a substitute. Happy people approach retirement with optimism and excitement.

A few of my own thoughts: Many senior interventionalists are part of a special group of people who were there at the beginning. Much of that history has been recorded now, but treasures await discovery. SCAI and other societies can have great value as facilitators.

We can only pass along wisdom when we avoid the maudlin trap of reminiscence. We (and SCAI) need to keep historical conversations separated from advisory work for younger interventionalists. Like church and state, each functions best when they have clear boundaries.

Old guys and gals don't really rule. For myself, I've realized I help the team by listening much more and speaking much less, a good approach at any age, especially for senior colleagues. If nothing else, it lets younger leaders lead—they'll come to you when you‘re needed.

Part II—Transitions and licenses

**Bob Applegate asks**, "what anyone who has transitioned is doing with Society membership, medical licenses, MOC, etc.?"

**Spencer King, Atlanta, GA**: I have emeritus status in SCAI, ACC, and ESC. After paying dues for 40–50 years, I am glad this is available.

**Bonnie Weiner, Worchester, MA**: I still have hospital privileges, even though I am less (but not none) clinically active, so have maintained license, insurance, and so on. I have not participated in MOC, I am lifetime certified in IM and Cardiovascular Medicine, and did not recertify in interventional cardiology through ABIM. Full disclosure, I have been a board member of NBPAS (thank you Paul Teirstein) for all the reasons that this organization exists as an alternative and am IC certified through them. Because I continue to be involved in clinical research and other quality activities in cardiology, I have maintained society memberships, although each year I question whether I should maintain some of them in terms of value provided. That internal discussion, however, preceded a decrease in clinical activity so wasn't related to situational changes.

**Carlos Ruiz**: I also converted to emeritus status in SCAI, ACC, and ESC. I kept my NY license and DEA, but no hospital privileges.

**John Bittl**: In retirement, I have kept my MA license and my DEA number, but I write no prescriptions and have no hospital privileges. I am a member of the Mass Medical Society, to continue to receive the NEJM and to get a group rate for Mass BCBS Medex insurance. I have switched over to emeritus status with the ACC, to continue to receive the JACC journals and to participate in editorial boards and the publications committee for the JACC journals—at least for the time being. Like Bonnie, I am lifetime-certified in internal medicine and cardiovascular medicine with the ABIM, but I have not been certified a third time for the interventional boards or again for endovascular interventions with the American Board of Vascular Medicine (ABVM).

A mid-career interventionalist view

**Kimberly A. Skelding, Wenatchee, WA**: I am humbled and grateful to have had the acquaintance of many of the people on this thread. I also hope that many if not all of you stay active in mentorship and guidance. Maybe SCAI could maintain an email list and list of interests you all would be willing to mentor for both clinical and professional/political issues. This could be a fruitful endeavor for both. Your experience in the entire career realm is exceedingly valuable. I could see some folks needing a one time "let me bounce this off you" to some who connect having a quarterly check-in. With the ability to do things virtually, this could be a fantastic experience for all. I for one over the last several years would have loved to have someone not connected to my career be able to offer advice along the way. This brain trust, bank of knowledge, wisdom laden group could help people avoid pitfalls and missteps in research and career choices and move the field forward without question. I thank you all for laying the foundation on which we all have benefitted. [M. K.—Thank you Dr. Skelding, you are the return on our investment and we're proud of you and your contributions.]

The Bottom Line

**Mort Kern, Long Beach, CA**:

> In thinking about the transitions described above, several concepts repeat themselves.
>
> Each transition plan is specific to the individual's mindset, health circumstances (both yours and your family's), life desires, and finances. Discuss the plan with your Chief or co-workers.
>
> A senior interventionalist should recognize when to quit. This might be the hardest decision. A trusted colleague may help you with this. Go out on a high note.
>
> To remain vital, an emeritus interventionalist should donate his time and wisdom, continue teaching, mentoring, and advising, if possible.
>
> The professional societies have not made special provisions for the emeriti, nor should we expect them to. Presenting angioplasty history and entertaining anecdotes only takes one so far.
>
> Consulting with industry or others may be possible, but don't count on this.

"Retool, retire, or even better, refocus"—pick one (see suggestions from Chris White and Aaron Kaplan).

Finally, I look again at Eric Bates' thoughtful review, "Requiem by a Member of the Inaugural Generation of Interventional Cardiologists."[1] I remember the many unique and wonderful anecdotes of great success, failures, technical advances, and radical changes, reflective of the 40-year overnight success story of interventional cardiology.

To my inaugural generation, or should I say, my Gen (i) colleagues, I say thank you. We enjoyed the once-in-a-lifetime opportunity to be involved in the birth, growth, and maturation of a new medical specialty. Like many of my colleagues, I have a strong bitter-sweet feeling about passing the torch. I hope to hand it off with style and grace. While it may be that the meek will inherit the earth, it is the bold that will inherit interventional cardiology.

## CONFLICT OF INTEREST

Dr. Kern is a consultant or speaker for Abbott Inc., Boston Scientific, Philips Inc., Acist Medical Inc., and Opsens Inc.

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