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Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Retirement

Learning Objectives
After reading these articles, you should be able to:

1. Describe some of the financial plans and tools available for clinicians to optimally prepare for retirement.
2. Identify the pre-retirement tasks and activities that can help clinicians prepare to successfully close their practices.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Closing a Practice: Some Practical Suggestions

James T. Hilliard, Esq. Connor & Hilliard, P.C. Assistant Professor (Legal Medicine), Harvard Medical School, part-time.

Mr. Hilliard has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Dr. R is a psychiatrist in his late 60s with a thriving private practice. One day, he suddenly feels dizzy and out of sorts. After being examined by another physician, he is diagnosed with a stroke. His neurologist cannot say if he will fully recover or be able to practice medicine again. Dr. R and his family know that he might suddenly need to retire.

A nightmare scenario? Perhaps. But it's not as uncommon as you might think.

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In Summary

- Following a specific checklist of tasks, such as informing patients and making decisions about records and insurance, can help make closing a practice an organized process.
- To reduce the stress of an unplanned retirement on family and patients, it can be helpful for clinicians to create instruction lists, maintain up-to-date records, and designate an administrator.
- Resources such as professional records management companies and online APA worksheets can help streamline the process of managing patient records after retirement.

Q&A With the Expert

Financial Planning for Retirement

Colin Wiens, CFP, MBA

Senior Financial Advisor, Larson Financial Group, LLC. Registered Representative, Larson Financial Securities, LLC.

Mr. Wiens discloses that he receives various forms of compensation for financial advising services. Dr. Carlat has reviewed this article and has found no evidence of bias in this educational activity.

TCPR: How is financial advising different for medical professionals?

Wiens: Because of the lengthy period of training, doctors begin their first "real" jobs 8–10 years after many of their friends from college. And, depending on specialty, burnout may cause a physician to retire a few years earlier than the average American. Both these factors lead to a compressed retirement saving timeline.

TCPR: How much money should we be saving for retirement?

Wiens: First, determine what sort of lifestyle you'd like in retirement. Then quantify your living expenses, based on your retirement activities and lifestyle goals. Generally, physicians aim to replace 40%–60% of their pre-retirement income once in retirement. For example, if you earned $250,000 per year before taxes in your clinical practice, you may want to build enough in Social Security, retirement accounts, passive income, etc, to provide $100,000–$150,000 of after-tax income in the future. In my experience, once the goals are set and quantified, the average physician needs to save 20%–30% of gross annual income for retirement, beginning at completion of residency or fellowship and continuing until the physician's late 50s or early 60s.

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Closing a Practice: Some Practical Suggestions

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Someday you will retire, and while the best-case scenario is a carefully planned exit, fate does not always respect our wishes. This is why it's wise to develop a plan before you need it.

The following article offers some practical suggestions based on my experiences counseling psychiatrists who are planning for retirement or who have faced unforeseen circumstances causing them to close their practices. Here, we will consider both planned and unplanned retirement scenarios.

Planned retirement

Let's start by outlining a suggested sequence of pre-retirement tasks, many of which are identical to those required in an unplanned retirement. The difference in an unplanned retirement is that someone else will complete these tasks for you. This might be your spouse, one of your children, or a colleague. In some cases, you might want to pre-designate a "special administrator" to oversee the process as part of your estate plan. This administrator is typically an attorney with experience in estate issues.

The following is a look at the steps you should take before closing your practice.

Inform your board of medicine

Most states require that you go through a formal process of applying to give up your license. Boards typically want to know whether you have any pending malpractice complaints, and they will want you to agree to make records available to your patients for a certain period after retirement (which varies from state to state). If you are planning a partial retirement, there are often options for restricted licenses. For example, if you plan to do purely administrative work not involving patient contact, you can usually get a limited license that may not require either continuing education credit or malpractice insurance.

Inform your patients

Informing patients of the need to end treatment because of your retirement can be difficult. Accordingly, you should approach it thoughtfully and with plenty of lead time. Depending on your type of case load (medication management and/or psychotherapy), a 6- to 9-month lead time is appropriate. In most cases, you can tell patients in person about your decision while at the same time handing them a letter with referral information. You might decide that an extra degree of caution is worthwhile for select patients: either those at high risk for decompensation or those who are likely to become litigious. For such cases, you should send the letter by registered mail to ensure that the patient receives it. Finally, document in the record that you informed your patient of your retirement, including whether you did so orally, in writing, or both.

Why do I suggest a 6- to 9-month lead time for informing patients? While there are no actual laws or regulations spelling out how much lead time to give patients, 6 to 9 months is an accepted standard of care. This accounts for the fact that it can take a long time for patients to find another physician, especially in areas where psychiatrists are in short supply.

The process of notification and follow-up is very important to avoid a complaint of abandonment, which is legally defined as "the cessation of treatment without a reasonable notification when the patient continues to be in need of treatment." Although you are not required to ensure that every one of your patients finds another practitioner, you must make a reasonable effort to provide your patients with resources within their geographic area. "Reasonable" is open to interpretation. Providing patients with a list of local prescribers or clinics/hospitals to contact is usually good enough. You can also advise them to contact their insurance company for a list of local providers. Simply

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Closing a Practice: Some Practical Suggestions
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asking patients to "find another doctor" on their own usually is not advisable.

How much should you tell your patients about why you are retiring? It's up to you; you can provide as much or as little personal detail as you judge to be appropriate. As is true in any clinical situation, you should be aware that some patients may not deal well with overly detailed disclosure about your personal life. You might want to plan additional sessions to help some patients deal with the transition.

Make records available to patients and subsequent treaters

If patients request it, offer to send a copy of their records to a new treater, although it's more common for new clinicians to request records from you once they see your patients. Make sure to send copies only, and retain the original record in your files.

How long should you retain patient records? While regulations may vary by state, most boards of medicine require that you retain all patient records for at least 7 years from the date of the last patient encounter (if the patient is a minor, the rule is 7 years or up to age 18, whichever is longer).

In addition to storing records, you have to arrange a way for patients to access those records for the 7-year period. If you have an electronic medical record, this can be an easy process. But if you use paper records, you may have hundreds or even thousands of charts. How should you arrange for access in this situation? Here are three options for managing your records after retirement:

1. The best way is generally to keep your own records and to respond to requests for access the same way you always have. To keep things manageable, destroy records that are beyond the 7-year cutoff date, although you should maintain a list of destroyed records, along with a brief comment about the patient and the date of the last clinical encounter.
2. If you are unable or unwilling to be the keeper of your records, you can ask a colleague to maintain them for you. If you're lucky, your colleague will do this for free, but otherwise you should agree on a fee in advance—both for the colleague's trouble and for the costs of preparing and mailing records.
3. Finally, there are professional records management companies, such as Iron Mountain, that will do everything for you for a fee. Make sure any company you enlist is HIPAA-compliant.

Note that different states dictate different allowable charges for handling and copying of records; check with your board of medicine. If records are requested for a Social Security claim, you are usually not allowed to charge for them. It's also a good idea to retain your business records, such as tax returns, office bills, etc, for a minimum of about 6 years.

Know rules for malpractice protection after retirement

If an alleged incident of malpractice occurred during active practice, retirement does not protect you against the claim. Accordingly, maintaining malpractice insurance for a period after retirement is an absolute necessity. How long depends on the statute of limitations in your state.

Insurance policies vary, and you should consult with your malpractice insurer as soon as you have decided to retire to discuss your options for post-retirement coverage. If you have a so-called "occurrence" policy, that policy will provide coverage for all claims based on acts that "occurred" when the insurance was in effect, regardless of when the claim is actually made. If you have this kind of policy, you wouldn't have to continue active coverage after retirement. But if you have a "claims made" policy, you're covered only if the insurance is in place at the time the claim is filed. In that case, you would need to pay for a "tail" insurance policy.

Unplanned retirement

An unplanned retirement generally occurs due to death or illness. While this is a topic most of us would prefer to avoid, setting up a detailed plan in the event of your untimely demise will help your grieving family and friends to deal with the logistics of closing your practice.

Checklists for Closing Your Practice

Planned retirement

- ❑ Inform medical board
- ❑ Inform your patients
- ❑ Make records available for future requests
- ❑ Retain business records
- ❑ Make decisions about malpractice insurance

Unplanned retirement

- ❑ Consider giving "just in case" referral letters to patients
- ❑ Periodically review your old records and destroy those that are past the last date required by your state licensing board (typically 7 years)
- ❑ Assign someone to be your administrator (eg, spouse, child, colleague, attorney)
- ❑ Create a list of organizations for your administrator to contact
- ❑ Leave instructions for how to locate contact information for active patients to send them news of your situation and referral options

Note: See the "Helpful retirement resources" section below for a link to more extensive templates.

Helpful retirement resources

The American Psychiatric Association (APA) has developed a number of helpful practice resources for clinicians on the topic of retirement. Although these resources are generally available only to active members of the APA, the organization has graciously agreed to make them available to readers of *The Carlat Psychiatry Report*. Because these materials were originally written in 2007, we have updated their checklists and templates to make them more relevant to current practice environments. We have also added several new templates to make your transition to retirement even easier. For the planned and unplanned retirement toolkits, please see: http://thecarlatreport.com/RetirementToolkits

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Expert Interview

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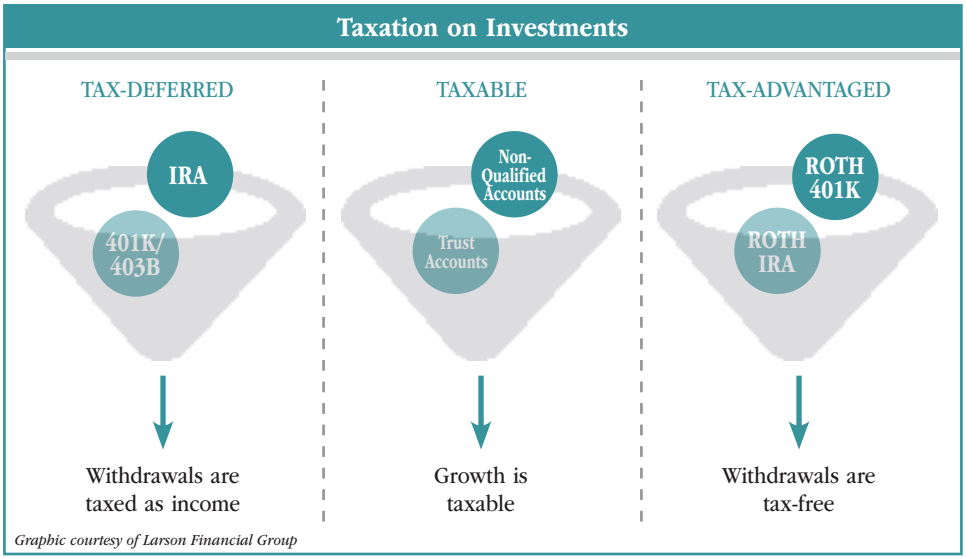
TCPR: Let's address growing what we save. What's the difference among the savings vehicles: IRAs, SEP IRAs, Roth IRAs, 401(k)s, etc?

Wiens: All of the items you mentioned are different types of retirement accounts. To help differentiate among them, I often think about the way they are taxed. First, let's categorize the different types of accounts:

- Tax-deferred: often referred to as "tax-sheltered," these are the retirement accounts we traditionally think of, including 401(k), 403(b), SEP IRA, traditional IRA, pension plan, and 457(b)
- Taxable savings: savings accounts, brokerage accounts, and other "trading" accounts
- Tax-advantaged: Roth IRA, Roth 401(k), Roth 403(b), 529 plans when used for qualified college expenses

Also, see the diagram below.



Graphic courtesy of Larson Financial Group

TCPR: How do the tax-deferred accounts save money?

Wiens: Let's assume that you have $18,000 that you'd like to put toward retirement and you're in the 33% tax bracket.

- If you contributed the $18,000 to a 401(k), which is tax-deferred, you wouldn't pay *income taxes* on the $18,000 (saving you $5,940).
- Then let's assume your investment returned a 5% dividend ($900 in income). If you held this in a taxable account, you'd have to pay dividend tax on it. But since it's in the 401(k), you won't pay any taxes until you take the money out in retirement, when you may be in a lower tax bracket than you are today. If the $900 was taxed as *ordinary* dividends, the 401(k) would save you an additional $297 in income tax today. Since you don't pay tax on that income, you have more principal to grow next year—this compounds growth faster than in a taxable investment account.

TCPR: How much can you contribute to a 401(k)?

Wiens: An employee can contribute $18,000 per year, plus a $6,000 catch-up amount for those 50 and older. But in addition to that, companies can match your 401(k) contribution. The amount of the match varies and is determined by the employer. The neat thing about running your own practice is that *you are your own employer* and you can set your own match. Many of my self-employed physician clients are able to contribute a total of $54,000 (the 2017 IRS limit) between the employee and employer, plus an additional $6,000 catch-up for those 50 and older.

TCPR: What are the advantages of a 401(k) over a SEP IRA?

Wiens: I see three advantages for self-employed doctors to use a 401(k) over a SEP IRA:

- Depending on income and what legal/tax entity the practice is (eg, LLC, sole proprietorship, S corporation, etc), a doctor may be able to contribute more to a 401(k) than a SEP IRA. For example, a 52-year-old self-employed psychiatrist with no employees netting $200,000 a year can put about $38,000 into a SEP IRA. Using a 401(k), that same doctor could contribute $60,000. You can run your own numbers using Vanguard's online contribution calculator (https://personal.vanguard.com/us/SbsCalculatorController).
- Secondly, you can borrow from a 401(k) should you ever need a low-interest loan. The interest you pay on the loan goes back into your own 401(k). Please note a 401(k) loan should typically only be used for short-term needs, and I recommend paying these loans back promptly.
- Lastly, a 401(k) enables you to use a tool we call the "backdoor Roth IRA" that can't be used with a SEP IRA.

TCPR: What's a "backdoor Roth IRA?" I thought most doctors made too much to use a Roth IRA.

Wiens: That's right—in 2017, if a married physician files taxes jointly and has an income of more than $196,000, that physician can't contribute to a Roth IRA directly. That's unfortunate, because Roth IRAs can be powerful tools—the contributions are funded after-tax, but when you withdraw funds in retirement, you pay no taxes on the distributions. The strategy for high-income individuals to fund a Roth IRA is often referred to as the "backdoor Roth IRA" (see https://www.bogleheads.org/wiki/Backdoor_Roth_IRA). Here are the steps:

1. An individual contributes to a non-deductible IRA, as there are no income limitations on these contributions.
2. The individual then converts the non-deductible IRA into a Roth IRA. Voila, Roth IRA funded through a backdoor.

There are some things that could cause hiccups (an existing balance in a pre-tax IRA or SEP IRA, for example), so I recommend that physicians seek the advice of a qualified accountant to ensure they are implementing the strategy appropriately. However, if used properly, the tax savings can be significant.

TCPR: I've heard about Roth 401(k)s; do these have the same income limits?

Wiens: Roth 401(k)s are like a Roth IRA inside of your 401(k), and luckily, they have no income limits. Additionally, they have the same contribution limits as a traditional 401(k): $18,000 per employee, with a $6,000 catch-up for those over 50.

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Expert Interview

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TCPR: Can you fund both a Roth 401(k) and a traditional 401(k)?

Wiens: Yes, but the *total* contribution between *both* accounts can't be higher than the $18,000 with $6,000 catch-up limit.

TCPR: And when can you start taking money out of these retirement accounts?

Wiens: Generally speaking, you can withdraw from qualified retirement plans without a penalty starting at age 59 ½.

TCPR: So if you're still making a high income and therefore are at a high tax bracket when you're 60 or 65, you can take Roth IRA money out and you won't pay any taxes on the investment income it has generated?

Wiens: Yes, that's correct. And there's another possible benefit to a Roth IRA. It could be that in 20 years tax policies will have changed and the overall federal or state tax rates are higher. Perhaps you were planning to be in a 25% bracket at retirement, but tax changes have increased your bracket to 35%. In that case, you'd be thankful you had the foresight to invest some of your money into a Roth IRA or Roth 401(k).

"I see many physicians invest almost entirely in tax-deferred accounts because of the general consensus that you are in the highest tax bracket you will ever be in, and in retirement you'll be in a lower tax bracket. But that's not necessarily going to be true."

Colin Wiens, CFP, MBA

TCPR: So deciding on whether to use a tax-deferred 401(k) or a Roth 401(k) is a little complicated. You're saying that it might be good to invest some money in both, because if you do, you will have more flexibility at retirement. That way, if you are indeed at a lower tax bracket, you could start withdrawing from a tax-deferred 401(k) or a SEP IRA; but if your tax bracket is higher, you can choose to withdraw money from your Roth bucket.

Wiens: Yes, you can strategize when you take money out of each bucket. And one of those buckets isn't necessarily better than the other bucket. Having money in *both* of those buckets lets you strategically influence your own tax rate in retirement.

TCPR: Many of us in psychiatry like to continue to work, at least part time, for many years, and we may not feel the need to withdraw from retirement accounts for a while. When are we required to start withdrawing?

Wiens: For the tax-deferred investments like 401(k)s and SEP IRAs, you are required to start withdrawing funds at age 70 ½ due to a rule called Required Minimum Distributions (RMDs). RMDs are the government's way of basically saying, "Look, you've never paid income taxes on the contributions, and we've never made money on the growth of this money, and you're going to die sometime soon, so we want our taxes now."

TCPR: I see. What's the last type of investment?

Wiens: The last type is a normal taxable investment account. You contribute to a brokerage account with after-tax money, and if it grows each year and pays dividends, you have to pay taxes on that. Also, if you sell it at a gain, you have to pay capital gains taxes. You typically pay more taxes on those accounts, and they are generally not as well protected as qualified retirement accounts. Accordingly, we encourage most physicians to focus on contributing more into the tax-deferred and tax-advantaged buckets.

TCPR: In your experience working with physicians, do you find a pattern of how they choose to invest their money in the scheme of three buckets?

Wiens: I see many physicians invest almost entirely in tax-deferred accounts because of the general consensus that you are in the highest tax bracket you will ever be in, and in retirement you'll be in a lower tax bracket. But that's not necessarily going to be true. One reason for this myopia is that most accountants are very focused on increasing tax deductions. Putting money in a 401(k) saves taxes now, and we often judge how our accountants perform based on how much tax they can save us *today*. Conversely, if you contribute to a Roth IRA or 401(k), it saves you nothing today, but it may save you money 20 years down the road. As a result, many physicians are missing out on those tax-advantaged plans.

TCPR: I'd like to shift to the question of how we should get advice for investing. In the past, there was an expectation that if you made a decent income and saved a lot of money, you would hire a money manager to invest your money. A money manager would charge an up-front sales charge and/or an annual fee of around 1%–2% of your assets, and you would hope to outperform the market. Lately, that's shifted: we hear that "index funds" actually outperform money managers, and there are now cheaper ways of getting advice.

Wiens: There are generally two philosophies to investing: active investing and passive investing. Here's how they break down:

- Active investing is when a money manager says, "I have experience and insight into the market, and I'll use that special knowledge to choose the right investments to achieve growth and profit. If you want to benefit from this, I'll charge you a fee for my expertise."
- Passive investing says that no one can consistently predict or outperform the market in a way that is statistically relevant or even better than a coin flip. So, instead of trying to beat the market, passive investing uses index funds or broadly diversified funds. An index fund is a collection of stocks that track a particular index. For example, the S&P 500 (Standard and Poor 500) tracks 500 large U.S. publicly traded companies. There are many other index funds tracking different-sized companies and different parts of the world, such as small companies, emerging markets, and other foreign company indices.

Which is better? As it turns out, over the last few decades, the research and academic data show the passive philosophy beating the active philosophy, especially when portfolios are properly monitored and rebalanced to stay in line with an individual investor's risk tolerance and time horizon. But it's still a hot debate. According to the financial analysis firm Morningstar, one strong indicator of future performance is a fund's expense ratio, or annual cost (http://beta.morningstar.com/articles/752485/fund-fees-predict-future-success-or-failure.html). Index funds tend to have much lower internal expense ratios, which allows more of the investor's

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Research Updates IN PSYCHIATRY

DEPRESSION

Aripiprazole Augmentation May Improve Remission Rates in MDD

REVIEW OF: Mohamed S et al, *JAMA* 2017;318(2):132–145

It seems like an endless debate: When a patient does not respond to the first trial of an antidepressant, what should we do? Switch to something else? Augment with another agent? If the latter, how often should that augmenting agent be an atypical antipsychotic? The VA Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D) trial was conducted to answer some of these questions. Specifically, the study compared the effectiveness and adverse effects of switching to bupropion SR, augmenting with bupropion SR, or augmenting with aripiprazole.

In this randomized controlled trial, 1,522 patients with non-psychotic major depressive disorder (MDD) who had failed at least one adequate 6-week course of an SSRI, an SNRI, or mirtazapine were recruited from the Veterans' Administration (VA). Most of the patients were male (85%) and white (69%), and had an average age of 54.4. Patients were randomly assigned to one of three groups: switching to bupropion (most common dose 200 mg twice daily, n = 511), augmenting with bupropion (most common dose also 200 mg twice daily, n = 506), or augmenting with aripiprazole (most common dose 10 mg daily, n = 505). After 12 weeks of treatment, remission and response rates were: switch-bupropion: remission 22%, response 62%; augment-bupropion: remission 27%, response 66%; augment-aripiprazole: remission 29%, response 74%. Augmenting with aripiprazole yielded statistically superior remission rates than switching to bupropion (P = .02) and superior response rates than either of the bupropion arms. Somnolence, akathisia, and weight gain occurred more frequently in the aripiprazole group. Most dramatically, in a subset of patients who continued the trial for 36 weeks, 25% of the aripiprazole group gained at least 7% of body weight as opposed to only 5% of both bupropion groups.

TCPR'S TAKE

Aripiprazole augmentation was the most effective strategy for patients who had not responded to a single antidepressant trial, beating both switching to and augmenting with bupropion. While aripiprazole's superiority was not huge, it was clinically significant, with a number needed to treat (NNT) of around 10 when compared with switching to bupropion. But the price of this higher response rate is a cluster of side effects, including weight gain, akathisia, and somnolence. In addition, these results may not generalize to non-VA populations, such as women of any age and younger men. Nonetheless, this large and well-designed study should encourage us to consider aripiprazole augmentation as a solid second-step strategy in depression treatment.

—Ricardo Arechiga, PharmD candidate (2018)

Mr. Arechiga has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

SOMATIC SYMPTOM DISORDER

Fluoxetine Plus CBT for Somatic Symptom Disorder

REVIEW OF: Fallon BA et al, *Am J Psychiatry* 2017;174(8):756–764

Somatic symptom disorder (formerly known as hypochondriasis) is pretty common, with a prevalence of 5%–7%, and is much more likely to afflict women than men, with a gender ratio of about 10:1. While both psychotherapy and SSRI treatment are helpful, there is limited evidence about the efficacy of combining therapy with medication. A new study sought to remedy this gap.

Researchers recruited 195 people with hypochondriasis (the study occurred before DSM-5) and randomly assigned them to one of four groups: placebo, cognitive behavioral therapy (CBT), fluoxetine, or combination treatment with both CBT and fluoxetine. CBT sessions were delivered from a scripted manual to participants in six 60-minute sessions on a weekly basis, followed by 2 biweekly and then 3 monthly boosters by experienced therapists. Fluoxetine and placebo groups were both given 20- to 30-minute medication management appointments with psychiatrists. Fluoxetine was started at 10 mg QD and gradually increased up to 80 mg QD as tolerated. Patients in the combination group met with both a therapist and psychiatrist. Response was defined as a 25% improvement in symptom severity.

Hypochondriasis symptoms were evaluated at weeks 6, 12, and 24. Based on primary outcome measures at week 24, patients assigned to combination treatment had the highest response rate (47.2%)—higher than the therapy group (39.6%) or the placebo group (29.5%), but not statistically significantly higher than the fluoxetine group (44.4%). However, on a variety of secondary measures, the advantage of combination treatment over fluoxetine alone was less pronounced, and in some cases fluoxetine alone seemed more effective. Interestingly, patients in the fluoxetine-alone group ended up with a mean dose of 40 mg/day; this was higher than patients in the combination group, who took a mean dose of 30.9 mg/day. Adverse events were mild, and were similar in all four treatment groups.

TCPR'S TAKE

Fluoxetine was effective for symptoms of hypochondriasis. Adding CBT provided only a small additional benefit over fluoxetine alone, although this benefit might have been greater if the dose of fluoxetine in the combination group had been higher. Bottom line, you should consider fluoxetine treatment for your patients with somatic symptom disorder, with or without added CBT.

—Shirley Tsai, PharmD candidate (2018)

Ms. Tsai has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. You have recently left your job at a hospital where you received benefits, including a matching retirement plan. You are now a self-employed clinician in private practice and plan to open a 401(k) or a SEP IRA. What would be one advantage of using a 401(k)? (LO #1)
   - [ ] a. You can withdraw from a 401(k) without a penalty starting at age 57 ½
   - [ ] b. You can set a match amount of up to $70,000 per year since you are your own employer
   - [ ] c. You don't pay any taxes on 401(k) distributions when you withdraw the funds in retirement
   - [ ] d. You can borrow from a 401(k) and the interest will go back into your account
2. You are in the process of making sure your patient records are up to date in anticipation of retiring from your practice. Although your patients are mostly adults, you have seen children and adolescents from time to time. According to James Hilliard, which statement about record retention for minor patients is true? (LO #2)
   - [ ] a. Regulations are the same nationally: seven years or up to age 18, whichever comes first
   - [ ] b. Regulations may vary by state; a common requirement is seven years or up to age 18, whichever is longer
   - [ ] c. Regulations are the same nationally: seven years or up to age 21, whichever comes first
   - [ ] d. Regulations may vary by state; a common requirement is seven years or up to age 21, whichever is longer
3. You currently have a 401(k) tax-deferred investment account that has accrued a significant amount of savings. According to a government rule called Required Minimum Distributions, at what age are you required to start withdrawing funds from this account? (LO #1)
   - [ ] a. 65
   - [ ] b. 68 ½
   - [ ] c. 70 ½
   - [ ] d. 72
4. You and your colleague are discussing future plans for retirement, and the topic of malpractice comes up. Your colleague tells you that she has an "occurrence" insurance policy that protects her against any claims that occur during active practice. Therefore, she won't need "tail" coverage after retirement. You disagree, telling her that it is necessary to continue active malpractice coverage in all cases for a period of time after retirement. Who is correct? (LO #2)
   - [ ] a. You
   - [ ] b. Your colleague
5. In a recent study on improving outcomes in patients with major depressive disorder, patients augmenting with or switching to bupropion had more weight gain than those augmenting with aripiprazole. (LO #3)
   - [ ] a. True
   - [ ] b. False

Expert Interview

Continued from page 5

funds to work in the market. Accordingly, paying attention to the investment's costs is worthwhile.

TCPR: But we still need advice on which index funds to invest in.

Wiens: Yes, and for that, having a financial advisor may make sense. For example, a passive investment advisor may talk to you about the mix of index funds that's best for your situation and risk level. The advisor may also counsel you on the appropriate tax buckets to use to reduce your tax liability today and in the future.

TCPR: That makes sense. So how do we go about choosing a financial advisor?

Wiens: Begin by understanding how advisors get paid:

1. Advisors may receive a *commission* selling a particular product, like an active mutual fund.
2. Advisors who work for insurance companies may receive a commission for advising you to buy an insurance-based product.
3. Finally, there are fee-for-service advisors, who get paid by you to give advice and/or manage your investments.

TCPR: Thank you for your time.

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THE CARLAT REPORT: PSYCHIATRY

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This Month's Focus:
Retirement

Next month in *The Carlat Psychiatry Report:* PTSD

Note From the Editor-in-Chief

While I appreciate *all* of my *TCPR* subscribers, there's one subscriber whom I value above all the others: my father. A psychiatrist who practices in the Bay Area, my father has been a loyal subscriber since Volume 1, Number 1, in January of 2003. For several years now, he has been asking me to publish an issue on how to retire from a psychiatric practice. "Great idea," I'd say, but then I'd promptly forget about it, distracted by the allure of "sexier" topics like pharmacogenetics and bipolar disorder. Finally, he showed me a retirement worksheet that he had devised in preparation for the day (who knows when?) he decides to retire. Chastened, I decided it was time for that retirement issue, and I tracked down experts to help educate all of us about the nuts and bolts of retiring. I even partnered with the APA in updating retirement checklists, which they have graciously agreed to make available to our subscribers. Thanks, dad—but don't retire too soon: you've got loads of patients still depending on you, and I know how much you love your job!