BY JOSEPH S. EASTERN, M.D.

Managing Your Dermatology Practice

When Can I Retire?

Retirement seems to be on a lot of readers' minds these days, and one of the more common questions I'm receiving is, "How will I know when I've accumulated enough money to safely retire?"

It's good that more physicians are turning their attention to this issue, because the road to retirement is fraught with many challenges.

The most common mistake made by physicians and other professionals is saving too little. We either never calculate or we underestimate how much we'll need to last through retirement.

We also tend to live longer than planned. As life expectancy increases, we run the risk of outliving our savings. And we don't face facts about long-term care. Not nearly enough of us have long-term-care insurance, or the means to self-fund an extended long-term-care situation.

Many people lack a clear idea of where their retirement income will come from, and even when they do, they don't know how to manage their savings correctly. Physicians in particular are notorious for not understanding investments. Many attempt to manage their practice's retirement plans with inadequate knowledge of how the investments within their plans work. Seeking the guidance of a qualified financial professional is often a far better strategy.

So, how *will* you know when you can safely retire? As with everything else, it depends. To arrive at any sort of reliable ballpark figure, you'll need to know three things: how much you realistically expect to spend annually after retirement, how much principal you'll need to generate that annual income, and how far your present savings are from that figure.

According to one oft-quoted rule of thumb, in retirement you should plan to spend about 70% of what you're spending now. That's nonsense. A few significant expenses, such as disability and malpractice insurance premiums, will be eliminated, but other expenses, such as travel, recreation, and medical care (including long-term-care insurance), will increase.

Financial experts say that too many physicians invest too aggressively. The most foolproof strategy is to sock away a fixed amount per month in a mutual fund.

My wife and I are assuming we will spend about the same in retirement as we spend now, and I suggest you do, too.

Once you have an estimate of your annual retirement expenses, you'll need to determine how much you'll need—usually in fixed pensions and invested assets—to generate that income. Social Security can be included, if you're over 50. If you're younger, don't count on receiving any entitlements since no one can predict how they will fare in coming generations.

Most financial advisors use the 5% rule: Assume the best you'll do on your money is 5% a year. So if your annual retirement expense estimate is $100,000, you'll need $2 million in assets. If you want to spend $200,000 per year, you'll need $4 million. That rule has worked well in most years, allowing for reasonable taxes, inflation, and rates of return.

How do you accumulate that kind of money? Financial experts say that too many physicians invest too aggressively. For retirement, safety is the key. The most foolproof strategy—seldom employed, because it's boring—is to sock away a fixed amount per month (after your retirement plan has been funded) in a mutual fund. With the power of compounded interest working for you, $1,000 per month for 25 years with the market earning 10% overall comes to almost $2 million.

Of course, it goes without saying that debt can destroy the best-laid retirement plans. If you carry significant debt, pay it off as soon as possible.

For those of you who are early in your careers, it is never too soon to think about retirement. Young physicians often defer contributing to their retirement plans be-

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Measuring Quality Could Narrow Racial Care Gap

BY MARY ELLEN SCHNEIDER
Senior Writer

PHILADELPHIA — Performance measurement is one way to help eliminate racial disparities in health care, Dr. John Z. Ayanian said at the annual meeting of the American College of Physicians.

Public and private payers must also do their part by maintaining accurate and complete data on race and ethnicity to help monitor disparities, said Dr. Ayanian, associate professor of medicine and health care policy at Harvard Medical School in Boston.

There has been some success in narrowing the racial care gap in areas where measurement is widespread. For example, a study published last year found both overall quality improvement in the use of β-blockers after acute myocardial infarction among Medicare managed-care beneficiaries and a significant narrowing of the racial gap in treatment.

The treatment gap between black and white beneficiaries had been 12% in 1997 and fell to 0.4% in 2002 (N. Engl. J. Med. 2005;353:692-700).

But there is still work to do, he said. For example, the same study shows that while overall quality improved in cholesterol control for coronary artery disease, the racial disparity is actually increasing in that measure. The study showed that the gap for cholesterol control, defined as LDL cholesterol below 130 mg/dL after discharge, between black and white patients was 13% in 1999, and the gap widened to 16% in 2002.

Lack of communication and trust between minority patients and physicians also are factors in care disparities, Dr. Ayanian said. Many physicians don't recognize the legacy of discrimination in health care, such as the Tuskegee syphilis study, that still fuels mistrust of the health care system among minorities, he said.

A cooperative national study conducted by Dr. Ayanian and his colleagues looked at new patient preferences for renal transplantation among end-stage renal disease patients ages 18 to 54 in Michigan, Alabama, Southern California, and the Washington metropolitan area in 1996-1997.

The researchers found small differences in the patient preferences for the transplant but larger differences in the referral for evaluation. For example, 86% of white men favored transplantation, and 82% were referred for evaluation. However, 81% of black men favored transplantation but only 58% were referred for evaluation (N. Engl. J. Med. 1999;341:1661-9).

In addition, most patients in the study said that they agreed with and trusted their physician. But white patients were more likely to trust and agree with physicians than black patients, and black patients received less information about transplantation.

Physicians, researchers, and policy makers need to work together to help eliminate disparities, Dr. Ayanian said at the meeting.

Expanded research funding is needed to better evaluate the causes of disparities, and financial incentives from payers can be used to reward "equitable and high-quality" care, he said.

In addition, there needs to be a broader focus on Hispanic, Asian, and Native American patients, he said. ■

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cause they want to save for a new house or for college for their children. There are tangible tax benefits that you get now, though, because your contributions usually reduce your taxable income and your investment grows tax free until you take it out.

No matter what your age, it's hard to motivate yourself to save for retirement because it generally requires spending less money now. You can always pay a financial planner to help you get organized, but you still must motivate yourself to change and follow the planner's advice.

In the end, the strategy is very straightforward: Put as much money as you can in a tax-deductible retirement plan, let it stay there and grow tax deferred until you take it out, and invest for the long term with your target amount in mind. It really is that simple. ■

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