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Fast *Facts*

- *Knowing your financial goals makes saving easier; it connects what you spend today with what you want to do in the future. Page 12.*
- *Start by knowing where the money is going. It's easy for doctors who juggle busy schedules to let money "slip through their fingers." Knowing how much your current lifestyle costs can also help in retirement planning. Page 15.*
- *If you're considering consolidating your student loans, mark June 30, 2007, in your calendar. That's the last day before interest rates change. If rates are predicted to go up, consolidating loans at 7.25% before the June 30, 2007, deadline will be a money saver. Page 19.*

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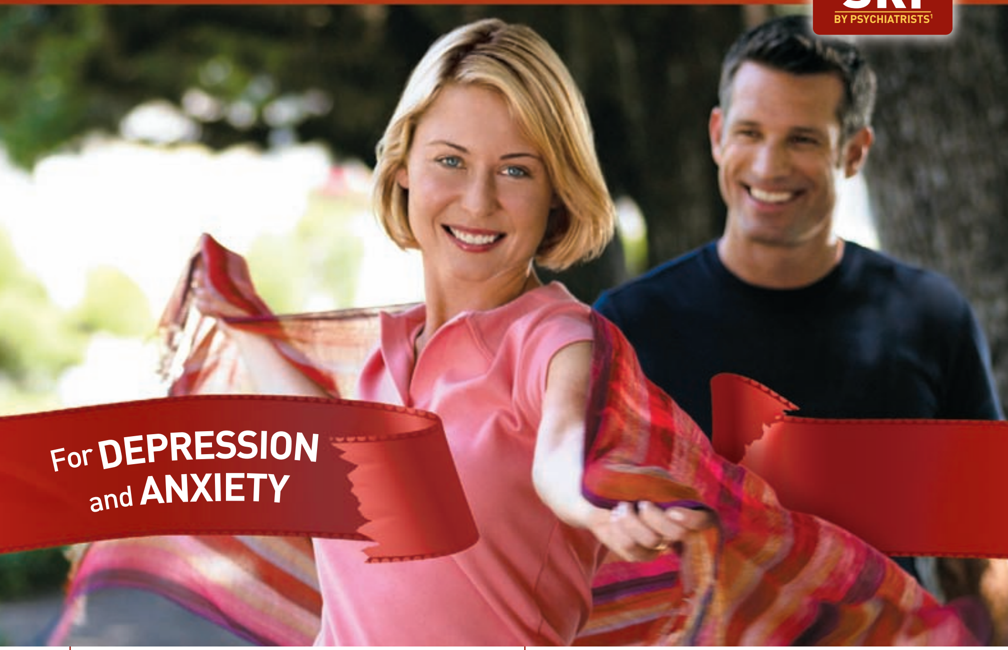
A POWERFUL SSRI
that's well tolerated

#1
PRESCRIBED
SRI
BY PSYCHIATRISTS[1]



UP TO 90% of depressed patients present with symptoms of anxiety[2]

PROVEN EFFICACY for Major Depressive Disorder and Generalized Anxiety Disorder[3]

Lexapro
escitalopram oxalate®

POWER TO ENJOY LIFE™

IMPORTANT SAFETY INFORMATION – Depression is a serious condition that can lead to suicidal thoughts and behavior. Antidepressants increased the risk of suicidal thinking and behavior (2% to 4%) in short-term studies of 9 antidepressant drugs in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Patients started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior, especially at the beginning of therapy or at the time of dose changes. This risk may persist until significant remission occurs. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients.

Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs), pimozide (see DRUG INTERACTIONS – Pimozide and Celexa), or in patients with hypersensitivity to escitalopram oxalate. As with other SSRIs, caution is indicated in the coadministration of tricyclic antidepressants (TCAs) with Lexapro. As with other psychotropic drugs that interfere with serotonin reuptake, patients should be cautioned regarding the risk of bleeding associated with the concomitant use of Lexapro with NSAIDs, aspirin, or other drugs that affect coagulation. The most common adverse events with Lexapro versus placebo (approximately 5% or greater and approximately 2x placebo) were nausea, insomnia, ejaculation disorder, somnolence, increased sweating, fatigue, decreased libido, and anorgasmia.

References: **1.** IMS National Prescription Audit. May 2005. **2.** Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry.* 9th ed. Philadelphia, Pa: Lippincott Williams & Wilkins;2003:552. **3.** LEXAPRO [package insert]. St Louis, Mo: Forest Pharmaceuticals, Inc.; 2006.

Please see brief summary of prescribing information for LEXAPRO on following page.

Visit the LEXAPRO website at www.lexapro.com

LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION

Rx Only

Brief Summary: For complete details, please see full prescribing information for Lexapro.

Suicidality in Children and Adolescents Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients. (See Warnings and Precautions: Pediatric Use) Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

CONTRAINDICATIONS Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see **WARNINGS**). Concomitant use in patients taking pimozide is contraindicated (see **Drug Interactions – Pimozide and Celexa**). Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro. **WARNINGS WARNINGS-Clinical Worsening and Suicide Risk Clinical Worsening and Suicide Risk** Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. There has been a long-standing concern that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients. Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Pooled analyses of short-term placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with MDD, OCD, or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal behavior or thinking (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. There was considerable variation in risk among drugs, but a tendency toward an increase for almost all drugs studied. The risk of suicidality was most consistently observed in the MDD trials, but there were signals of risk arising from some trials in other psychiatric indications (obsessive compulsive disorder and social anxiety disorder) as well. **No suicides occurred in any of these trials.** It is unknown whether the suicidality risk in pediatric patients extends to longer-term use, i.e., beyond several months. It is also unknown whether the suicidality risk extends to adults. **All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Such observation would generally include at least weekly face-to-face contact with patients or their family members or caregivers during the first 4 weeks of treatment, then every other week visits for the next 4 weeks, then at 12 weeks, and as clinically indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits. Adults with MDD or co-morbid depression in the setting of other psychiatric illness being treated with antidepressants should be observed similarly for clinical worsening and suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see **PRECAUTIONS and DOSAGE AND ADMINISTRATION—Discontinuation of Treatment with Lexapro, in full prescribing information for a description of the risks of discontinuation of Lexapro**). **Families and caregivers of pediatric patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for Lexapro should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. Families and caregivers of adults being treated for depression should be similarly advised. **Screening Patients for Bipolar Disorder:** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Lexapro is not approved for use in treating bipolar depression. **Potential for Interaction with Monoamine Oxidase Inhibitors In patients receiving serotonin reuptake inhibitor drugs in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Furthermore, limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that Lexapro should not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping Lexapro before starting an MAOI. Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI.** ***Serotonin Syndrome:*** The development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Lexapro treatment, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated (see **CONTRAINDICATIONS** and **WARNINGS - Potential for Interaction with Monoamine Oxidase Inhibitors.**) If concomitant treatment of Lexapro with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **PRECAUTIONS - Drug Interactions**).The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended (see **PRECAUTIONS - Drug Interactions**). **PRECAUTIONS** Information for Patients Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of Lexapro and triptans, tramadol or other serotonergic agents. **Drug Interactions** ***Serotonergic Drugs:*** Based on the mechanism of action of SNRIs and SSRIs including Lexapro, and the potential for serotonin syndrome, caution is advised when Lexapro is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (see **WARNINGS - Serotonin Syndrome**). The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended (see **PRECAUTIONS - Drug Interactions**). ***Triptans:*** There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Lexapro with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **WARNINGS - Serotonin Syndrome). General** Discontinuation of Treatment with Lexapro During marketing of Lexapro and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Lexapro. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate (see **DOSAGE AND ADMINISTRATION** in full prescribing information). Abnormal Bleeding Published case reports have documented the occurrence of bleeding episodes in patients treated with psychotropic drugs that interfere with serotonin reuptake. Subsequent epidemiological studies, both of the case-control and cohort design, have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. In two studies, concurrent use of a nonsteroidal anti-inflammatory drug (NSAID) or aspirin potentiated the risk of bleeding (see **Drug Interactions**). Although these studies focused on upper gastrointestinal bleeding, there is reason to believe that bleeding at other sites may be similarly potentiated. Patients should be cautioned regarding the risk of bleeding associated with the concomitant use of Lexapro with NSAIDs, aspirin, or other drugs that affect coagulation. Hyponatremia Cases of hyponatremia and SIADH (syndrome of inappropriate antidiuretic hormone secretion) have been reported in association with Lexapro treatment. All patients with these events have recovered with discontinuation of escitalopram and/or medical intervention. Hyponatremia and SIADH have also been reported in association with other marketed drugs effective in the treatment of major depressive disorder. Activation of Mania/Hypomania In placebo-controlled trials of Lexapro in major depressive disorder, activation of mania/hypomania was reported in one (0.1%) of 715 patients treated with Lexapro and in none of the 592 patients treated with placebo. One additional case of hypomania has been reported in association with Lexapro treatment. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with racemic citalopram and other marketed drugs effective in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, Lexapro should be used cautiously in patients with a history of mania. Seizures Although anticonvulsant effects of racemic citalopram have been observed in animal studies, Lexapro has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarketing testing. In clinical trials of Lexapro, cases of convulsion have been reported in association with Lexapro treatment. Like other drugs effective in the treatment of major depressive disorder, Lexapro should be introduced with care in patients with a history of seizure disorder. Interference with Cognitive and Motor Performance In a study in normal volunteers, Lexapro 10 mg/day did not produce impairment of intellectual function or psychomotor performance. Because any psychoactive drug may impair judgment, thinking, or motor skills, however, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Use in Patients with Concomitant Illness Clinical experience with Lexapro in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using Lexapro in patients with diseases or conditions that produce altered metabolism or hemodynamic responses. Lexapro has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day (see **DOSAGE AND ADMINISTRATION** in full prescribing information). Because escitalopram is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. Until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with Lexapro, however, it should be used with caution in such patients (see **DOSAGE AND ADMINISTRATION** in full prescribing information). **Drug Interactions** CNS Drugs - Given the primary CNS effects of escitalopram, caution should be used when it is taken in combination with other centrally acting drugs. Alcohol - Although Lexapro did not potentiate the cognitive and motor effects of alcohol in a clinical trial, as with other psychotropic medications, the use of alcohol by patients taking Lexapro is not recommended. Monoamine Oxidase Inhibitors (MAOIs) - See **CONTRAINDICATIONS** and **WARNINGS**. **Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)** Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin potentiated the risk of bleeding. Thus, patients should be cautioned about the use of such drugs concurrently with Lexapro. Cimetidine - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of 400 mg/day cimetidine for 8 days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively. The clinical significance of these findings is unknown. Digoxin - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of citalopram and digoxin (single dose of 1 mg) did not significantly affect the pharmacokinetics of either citalopram or digoxin. Lithium - Coadministration of racemic citalopram (40 mg/day for 10 days) and lithium (30 mmol/day for 5 days) had no significant effect on the pharmacokinetics of citalopram or lithium. Nevertheless, plasma lithium levels should be monitored with appropriate adjustment to the lithium dose in accordance with standard clinical practice. Because lithium may enhance the serotonergic effects of escitalopram, caution should be exercised when Lexapro and lithium are coadministered. Pimozide and Celexa - In a controlled study, a single dose of pimozide 2 mg co-administered with racemic citalopram 40 mg given once daily for 11 days was associated with a mean increase in QTc values of approximately 10 msec compared to pimozide given alone. Racemic citalopram did not alter the mean AUC or C_{max} of pimozide. The mechanism of this pharmacodynamic interaction is not known. Sumatriptan - There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of an SSRI and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram) is clinically warranted, appropriate observation of the patient is advised. Theophylline - Combined administration of racemic citalopram (40 mg/day for 21 days) and the CYP1A2 substrate theophylline (single dose of 300 mg) did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated. Warfarin - Administration of 40 mg/day racemic citalopram for 21 days did not affect the pharmacokinetics of warfarin, a CYP3A4 substrate. Prothrombin time was increased by 5%, the clinical significance of which is unknown. Carbamazepine - Combined administration of racemic citalopram (40 mg/day for 14 days) and carbamazepine (titrated to 400 mg/day for 35 days) did not significantly affect the pharmacokinetics of carbamazepine, a CYP3A4 substrate. Although trough citalopram plasma levels were unaffected, given the enzyme-inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are coadministered. Triazolam - Combined administration of racemic citalopram (titrated to 40 mg/day for 28 days) and the CYP3A4 substrate triazolam (single dose of 0.25 mg) did not significantly affect the pharmacokinetics of either citalopram or triazolam. Ketoconazole - Combined administration of racemic citalopram (40 mg) and ketoconazole (200 mg), a potent CYP3A4 inhibitor, decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram. Ritonavir - Combined administration of a single dose of ritonavir (600 mg), both a CYP3A4 substrate and a potent inhibitor of CYP3A4, and escitalopram (20 mg) did not affect the pharmacokinetics of either ritonavir or escitalopram. CYP3A4 and -2C19 Inhibitors - *In vitro* studies indicated that CYP3A4 and -2C19 are the primary enzymes involved in the metabolism of escitalopram. However, coadministration of escitalopram (20 mg) and ritonavir (600 mg), a potent inhibitor of CYP3A4, did not significantly affect the pharmacokinetics of escitalopram. Because escitalopram is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease escitalopram clearance. Drugs Metabolized by Cytochrome P4502D6 - *In vitro* studies did not reveal an inhibitory effect of escitalopram on CYP2D6. In addition, steady state levels of racemic citalopram were not significantly different in poor metabolizers and extensive CYP2D6 metabolizers after multiple-dose administration of citalopram, suggesting that coadministration, with escitalopram, of a drug that inhibits CYP2D6, is unlikely to have clinically significant effects on escitalopram metabolism. However, there are limited *in vivo* data suggesting a modest CYP2D6 inhibitory effect for escitalopram, i.e., coadministration of escitalopram (20 mg/day for 21 days) with the tricyclic antidepressant desipramine (single dose of 50 mg), a substrate for CYP2D6, resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. The clinical significance of this finding is unknown. Nevertheless, caution is indicated in the coadministration of escitalopram and drugs metabolized by CYP2D6. Metoprolol - Administration of 20 mg/day Lexapro for 21 days in healthy volunteers resulted in a 50% increase in C_{max} and 82% increase in AUC of the beta-adrenergic blocker metoprolol (given in a single dose of 100 mg). Increased metoprolol plasma levels have been associated with decreased cardioselectivity. Coadministration of Lexapro and metoprolol had no clinically significant effects on blood pressure or heart rate. Electroconvulsive Therapy (ECT) - There are no clinical studies of the combined use of ECT and escitalopram. **Carcinogenesis, Mutagenesis, Impairment of Fertility** Carcinogenesis Racemic citalopram was administered in the diet to NMRI/BOM strain mice and COBS WI strain rats for 18 and 24 months, respectively. There was no evidence for carcinogenicity of racemic citalopram in mice receiving up to 240 mg/kg/day. There was an increased incidence of small intestine carcinoma in rats receiving 8 or 24 mg/kg/day racemic citalopram. A no-effect dose for this finding was not established. The relevance of these findings to humans is unknown. Mutagenesis Racemic citalopram was mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) in 2 of 5 bacterial strains (Salmonella TA98 and TA1537) in the absence of metabolic activation. It was clastogenic in the *in vitro* Chinese hamster lung cell assay for chromosomal aberrations in the presence and absence of metabolic activation. Racemic citalopram was not mutagenic in the *in vitro* mammalian forward gene mutation assay (HPRT) in mouse lymphoma cells or in a coupled *in vitro/in vivo* unscheduled DNA synthesis (UDS) assay in rat liver. It was not clastogenic in the *in vitro* chromosomal aberration assay in human lymphocytes or in two *in vivo* mouse micronucleus assays. Impairment of Fertility When racemic citalopram was administered orally to 16 male and 24 female rats prior to and throughout mating and gestation at doses of 32, 48, and 72 mg/kg/day, mating was decreased at all doses, and fertility was decreased at doses $\geq$ 32 mg/kg/day. Gestation duration was increased at 48 mg/kg/day. **Pregnancy-Nonteratogenic Effects** Neonates exposed to Lexapro and other SSRIs or SNRIs, late in the third trimester, have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see **WARNINGS**). Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1-2 per 1000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective, case-control study of 377 women whose infants were born with PPHN and 836 women whose infants were born healthy, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk. When treating a pregnant woman with Lexapro during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see **DOSAGE AND ADMINISTRATION** in full prescribing information). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. **Labor and Delivery** The effect of Lexapro on labor and delivery in humans is unknown. **Nursing Mothers** Racemic citalopram, like many other drugs, is excreted in human breast milk. There have been two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of citalopram by its mother and, in the second case, no follow-up information was available. The decision whether to continue or discontinue either nursing or Lexapro therapy should take into account the risks of citalopram exposure for the infant and the benefits of Lexapro treatment for the mother. **Pediatric Use** Safety and effectiveness in the pediatric population have not been established (see **BOX WARNING** and **WARNINGS—Clinical Worsening and Suicide Risk**). One placebo-controlled trial in 264 pediatric patients with MDD has been conducted with Lexapro, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of Lexapro in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use** Approximately 6% of the 1144 patients receiving escitalopram in controlled trials of Lexapro in major depressive disorder and GAD were 60 years of age or older; elderly patients in these trials received daily doses of Lexapro between 10 and 20 mg. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity of some elderly individuals to effects of Lexapro cannot be ruled out. In two pharmacokinetic studies, escitalopram half-life was increased by approximately 50% in elderly subjects as compared to young subjects and C_{max} was unchanged (see **CLINICAL PHARMACOLOGY**). 10 mg/day is the recommended dose for elderly patients (see **DOSAGE AND ADMINISTRATION** in full prescribing information). Of 4422 patients in clinical studies of racemic citalopram, 1357 were 60 and over, 1034 were 65 and over, and 457 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but again, greater sensitivity of some elderly individuals cannot be ruled out. **ADVERSE REACTIONS** Adverse event information for Lexapro was collected from 715 patients with major depressive disorder who were exposed to escitalopram and from 592 patients who were exposed to placebo in double-blind, placebo-controlled trials. An additional 284 patients with major depressive disorder were newly exposed to escitalopram in open-label trials. The adverse event information for Lexapro in patients with GAD was collected from 429 patients exposed to escitalopram and from 427 patients exposed to placebo in double-blind, placebo-controlled trials. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, standard World Health Organization (WHO) terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. **Adverse Events Associated with Discontinuation of Treatment Major Depressive Disorder** Among the 715 depressed patients who received Lexapro in placebo-controlled trials, 6% discontinued treatment due to an adverse event, as compared to 2% of 592 patients receiving placebo. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients). **Generalized Anxiety Disorder** Among the 429 GAD patients who received Lexapro 10-20 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the placebo rate, were nausea (2%), insomnia (1%), and fatigue (1%). **Incidence of Adverse Events in Placebo-Controlled Clinical Trials Major Depressive Disorder** Table 1 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The prescriber should be aware that these figures can not be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence (see **TABLE 1**). **TABLE 1: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Major Depressive Disorder* [Lexapro (N=715) and Placebo (N=592)]: Autonomic Nervous System Disorders:** Dry Mouth (6% and 5%); Sweating Increased (5% and 2%). **Central & Peripheral Nervous System Disorders:** Dizziness (5% and 3%). **Gastrointestinal Disorders:** Nausea (15% and 7%); Diarrhea (8% and 5%); Constipation (3% and 1%); Indigestion (3% and 1%); Abdominal Pain (2% and 1%). **General:** Influenza-like Symptoms (5% and 4%); Fatigue (5% and 2%). **Psychiatric Disorders:** Insomnia (9% and 4%); Somnolence (6% and 2%); Appetite Decreased (3% and 1 %); Libido Decreased (3% and 1%). **Respiratory System Disorders:** Rhinitis (5% and 4%); Sinusitis (3% and 2%). **Urogenital:** Ejaculation Disorder[1,2] (9% and <1%); Impotence[2] (3% and <1%); Anorgasmia[3] (2% and <1%).*Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo $\geq$ Lexapro: headache, upper respiratory tract infection, back pain, pharyngitis, inflicted injury, anxiety. [1]Primarily ejaculatory delay. [2]Denominator used was for males only (N=225 Lexapro; N=188 placebo). [3]Denominator used was for females only (N=490 Lexapro; N=404 placebo). **Generalized Anxiety Disorder** Table 2 enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia (see **TABLE 2**). **TABLE 2: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder* [Lexapro (N=429) and Placebo (N=427)]: Autonomic Nervous System Disorders:** Dry Mouth (9% and 5%); Sweating Increased (4% and 1%). **Central & Peripheral Nervous System Disorders:** Headache (24% and 17%); Paresthesia (2% and 1%). **Gastrointestinal Disorders:** Nausea (18% and 8%); Diarrhea (8% and 6%); Constipation (5% and 4%); Indigestion (3% and 2%); Vomiting (3% and 1%); Abdominal Pain (2% and 1%); Flatulence (2% and 1%); Toothache (2% and 0%). **General:** Fatigue (8% and 2%); Influenza-like symptoms (5% and 4%). **Musculoskeletal:** Neck/Shoulder Pain (3% and 1%). **Psychiatric Disorders:** Somnolence (13% and 7%); Insomnia (12% and 6%); Libido Decreased (7% and 2%); Dreaming Abnormal (3% and 2%); Appetite Decreased (3% and 1%); Lethargy (3% and 1%); Yawning (2% and 1%). **Urogenital:** Ejaculation Disorder[1,2] (14% and 2%); Anorgasmia[3] (6% and <1%); Menstrual Disorder (2% and 1%). *Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo Lexapro: inflicted injury, dizziness, back pain, upper respiratory tract infection, rhinitis, pharyngitis. [1]Primarily ejaculatory delay. [2]Denominator used was for males only (N=182 Lexapro; N=195 placebo). [3]Denominator used was for females only (N=247 Lexapro; N=232 placebo). **Dose Dependency of Adverse Events** The potential dose dependency of common adverse events (defined as an incidence rate of $\geq$5% in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg/day Lexapro-treated patients was greater (86%). Table 3 shows common adverse events that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group.**TABLE 3: Incidence of Common Adverse Events* in Patients with Major Depressive Disorder Receiving Placebo (N=311), 10 mg/day Lexapro (N=310), 20 mg/day Lexapro (N=125)]: Insomnia** (4%, 7%, 14%); **Diarrhea** (5%, 6%, 14%); **Dry Mouth** (3%, 4%, 9%); **Somnolence** (1%, 4%, 9%); **Dizziness** (2%, 4%, 7%); **Sweating Increased** (<1%, 3%, 8%); **Constipation** (1%, 3%, 6%); **Fatigue** (2%, 2%, 6%); **Indigestion** (1%, 2%, 6%).*Adverse events with an incidence rate of at least 5% in either of the Lexapro groups and with an incidence rate in the 20 mg/day Lexapro group that was approximately twice that of the 10 mg/day Lexapro group and the placebo group. **Male and Female Sexual Dysfunction with SSRIs** Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. Table 4 shows the incidence rates of sexual side effects in patients with major depressive disorder and GAD in placebo-controlled trials. **TABLE 4: Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials [**In Males Only: **Lexapro** (N=407) **and Placebo** (N=383)**]:** Ejaculation Disorder (primarily ejaculatory delay) (12% and 1%); Libido Decreased (6% and 2%); Impotence (2% and <1%). **[**In Females Only**: Lexapro** (N=737) **and Placebo** (N=636)**]:** Libido Decreased (3% and 1%); Anorgasmia (3% and <1%) There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **Vital Sign Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes** Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment. **ECG Changes** Electrocardiograms from Lexapro (N=625), racemic citalopram (N=351), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 3.9 msec for Lexapro and 3.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities. **Other Events Observed During the Premarketing Evaluation of Lexapro** Following is a list of WHO terms that reflect treatment-emergent adverse events, as defined in the introduction to the **ADVERSE REACTIONS** section, reported by the 1428 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. All reported events are included except those already listed in Tables 1 & 2, those occurring in only one patient, event terms that are so general as to be uninformative, and those that are unlikely to be drug related. It is important to emphasize that, although the events reported occurred during treatment with Lexapro, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 patients but at least 1/1000 patients. Cardiovascular - *Frequent:* palpitation, hypertension. *Infrequent:* bradycardia, tachycardia, ECG abnormal, flushing, varicose vein. Central and Peripheral Nervous System Disorders - *Frequent:* light-headed feeling, migraine. *Infrequent:* tremor, vertigo, restless legs, shaking, twitching, dysequilibrium, tics, carpal tunnel syndrome, muscle contractions involuntary, sluggishness, coordination abnormal, faintness, hyperreflexia, muscular tone increased. Gastrointestinal Disorders - *Frequent:* heartburn, abdominal cramp, gastroenteritis. *Infrequent:* gastroesophageal reflux, bloating, abdominal discomfort, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, polyposis gastric, swallowing difficult. General - *Frequent:* allergy, pain in limb, fever, hot flushes, chest pain. *Infrequent:* edema of extremities, chills, tightness of chest, leg pain, asthenia, syncope, malaise, anaphylaxis, fall. Hemic and Lymphatic Disorders - *Infrequent:* bruise, anemia, nosebleed, hematoma, lymphadenopathy cervical. Metabolic and Nutritional Disorders - *Frequent:* increased weight. *Infrequent:* decreased weight, hyperglycemia, thirst, bilirubin increased, hepatic enzymes increased, gout, hypercholesterolemia. Musculoskeletal System Disorders - *Frequent:* arthralgia, myalgia. *Infrequent:* jaw stiffness, muscle cramp, muscle stiffness, arthritis, muscle weakness, back discomfort, arthropathy, jaw pain, joint stiffness. Psychiatric Disorders - *Frequent:* appetite increased, lethargy, irritability, concentration impaired. *Infrequent:* jitteriness, panic reaction, agitation, apathy, forgetfulness, depression aggravated, nervousness, restlessness aggravated, suicide attempt, amnesia, anxiety attack, bruxism, carbohydrate craving, confusion, depersonalization, disorientation, emotional lability, feeling unreal, tremulousness nervous, crying abnormal, depression, excitability, auditory hallucination, suicidal tendency. Reproductive Disorders/Female* - *Frequent:* menstrual cramps, menstrual disorder. *Infrequent:* menorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses. *% based on female subjects only: N= 905 Respiratory System Disorders - *Frequent:* bronchitis, sinus congestion, coughing, nasal congestion, sinus headache. *Infrequent:* asthma, breath shortness, laryngitis, pneumonia, tracheitis. Skin and Appendages Disorders - *Frequent:* rash. *Infrequent:* pruritus, acne, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodule. Special Senses - *Frequent:* vision blurred, tinnitus. *Infrequent:* taste alteration, earache, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbance, eye infection, pupils dilated, metallic taste. Urinary System Disorders - *Frequent:* urinary frequency, urinary tract infection. *Infrequent:* urinary urgency, kidney stone, dysuria, blood in urine. **Events Reported Subsequent to the Marketing of Escitalopram** - Although no causal relationship to escitalopram treatment has been found, the following adverse events have been reported to have occurred in patients and to be temporally associated with escitalopram treatment during post marketing experience and were not observed during the premarketing evaluation of escitalopram: abnormal gait, acute renal failure, aggression, akathisia, allergic reaction, anger, angioedema, atrial fibrillation, choreoathetosis, delirium, delusion, diplopia, dysarthria, dyskinesia, dystonia, ecchymosis, erythema multiforme, extrapyramidal disorders, fulminant hepatitis, hepatic failure, hypoaesthesia, hypoglycemia, hypokalemia, INR increased, gastrointestinal hemorrhage, glaucoma, grand mal seizures (or convulsions), hemolytic anemia, hepatic necrosis, hepatitis, hypotension, leucopenia, myocardial infarction, myoclonus, neuroleptic malignant syndrome, nightmare, nystagmus, orthostatic hypotension, pancreatitis, paranoia, photosensitivity reaction, priapism, prolactinemia, prothrombin decreased, pulmonary embolism, QT prolongation, rhabdomyolysis, seizures, serotonin syndrome, SIADH, spontaneous abortion, Stevens Johnson Syndrome, tardive dyskinesia, thrombocytopenia, thrombosis, torsade de pointes, toxic epidermal necrolysis, ventricular arrhythmia, ventricular tachycardia and visual hallucinations.

Building up net worth is by no means an easy task, even for physicians. But what happens when those statements have been viewed and are stored away in a desk drawer? You go on with your life: your practice, your friends, your family, and whatever you do for enjoyment.

That's what really counts: how you live your life. Money, in some circumstances, may help you live it better, but that's not automatic. After all, only the first part of the term "financial planning" refers to money. The "planning" part may be the more important half. If you have a plan, you're more likely to wind up at the desired destination. Before you can plan effectively, though, you need to determine where you want to go.

To start on the right track, it helps to engage in the process of "financial visioning."

Financial visioning melds financial planning with life planning, and personal finances with personal values. The idea behind the process is that saving becomes easier if the goal is something beyond an impressive financial statement. It's not the money that's important—it's what you can do with the money. Think of it in those terms, and it becomes easier to forego a nice but unnecessary luxury in favor of saving toward a greater goal—say, your children's education, or perhaps a sabbatical to volunteer for an international relief agency. It may also give you the incentive you need to track spending and manage expenses, debt, and investments more purposefully, rather than letting money slip through your fingers.

Increasingly, financial planners are advocating this type of money approach. They know there's more to life than accumulated wealth. In recent years, many firms have developed tools and approaches to help their clients determine their spending and saving priorities.

"Our firm has a proprietary consulting service called the 'Wealth and Beyond' program," says Elfrena Foord of Foord, Van Bruggen, Ebersole & Pajak, a financial planning firm in Sacramento, Calif. "We ask people what their 'Beyond' looks like." To get an idea of clients' financial visions, Ms. Foord's firm asks these questions:

- What does your life look like beyond financial independence?
- What are satisfying ways you will spend your time?

- What reasons will you have to keep working if you don't need the money?
- Are there things you have always wanted to do but never had the time?
- What can you do now to create your new life while you are still working?

The answers can be revealing. "When we ask what would life look like beyond financial independence," says Ms. Foord, "we get answers like 'working for fun and not for money.' Physicians tell us they would like to have an easier schedule or do Doctors-Without-Borders type of volunteer work."

Once such visions for the future become apparent, they can be incorporated into a financial plan. "Clients become motivated to save more so they can move toward their goals faster," says Ms. Foord. "They want to do more than just make money, spend it, and not know where it went."

Once such visions become apparent, they can be incorporated into a financial plan. "Clients become motivated to save more so they can move toward their goals faster," says Ms. Foord. "They want to do more than just make money, spend it, and not know where it went. Once the vision is in place, we see clients working more closely with their spouse to develop a joint plan."

Beyond Retirement Planning

Although financial planners focus a great deal on saving for retirement and leaving a healthy estate for the next generation, those are far from the only reasons to have a financial plan. Most people have a variety of money goals. Balancing and prioritizing those goals can be a challenge, especially in the first few years in practice. Student loan repayment, home mortgage, insurance, child care, and tuition (not to mention day-to-day expenses) all compete with retirement for a piece of the pie. And, despite higher-than-average incomes, many physicians find there is not enough "pie" to feed all those goals at once.

By exploring your values and priorities, it can become easier to split the pie in a way that fits your life.

"In life, it is important to have a solid plan in order to achieve your goals with positive and timely results," says Alexander

Mikhaylov, founder of Financial Vision, a planning firm in New York City and Lathrup Village, Mich. “Drafting this plan requires not only pen and paper, but a clear vision or idea of where you’re headed and how you plan to get there. The same holds true for achieving your financial goals and dreams.”

According to Mr. Mikhaylov, many professionals, especially physicians, have difficulty finding enough time to draft a plan and thus reap its benefits down the road. “Whether your goals are to save for retirement, fund your child’s education, eliminate debt, or protect yourself and your loved ones with effective, low-cost life insurance, there are several steps you should take,” he says. If you can’t create your own vision, it may help to work

Values Activity: Priority Chart

1. List your own additional values in the “Values” section on the left.
2. Rank them in their order of importance to you in the “Priority Order” section on the right.

For instance, if both financial health and mental health are important to you, which one would you choose to address first if you had to make a choice?

Values	Priority Order
■ Rewarding career	____________________
	____________________
■ Financial health	____________________
	____________________
■ Mental health	____________________
	____________________
■ Spiritual health	____________________
	____________________
■ Physical health	____________________
	____________________
■ Family relationships	____________________
	____________________
■ ____________________	____________________
	____________________
■ ____________________	____________________
	____________________
■ ____________________	____________________

Source: Personal Financial Choices, Visa USA 2007.

with a financial professional.

At his firm, a financial-needs analysis plays a vital role. "We meet with clients for one hour to understand their current financial situation," says Mr. Mikhaylov, "and identify their financial vision—what it is they would like to accomplish—then compile a road map for a journey to success."

For some people, though, the road map may mark a difficult journey. "People have different personalities, priorities, and habits," says Mr. Mikhaylov. "When we look at spending and saving habits, we find that an individual's spending habits often reflect the spending habits of his or her parents."

For some people, though, the road map may mark a difficult journey. "People have different personalities, priorities, and habits," says Mr. Mikhaylov. "When we look at spending and saving habits, we find that an individual's spending habits often reflect the spending habits of his or her parents."

At an early age, according to Mr. Mikhaylov, people are programmed by their parents to do certain things in certain ways, which become habits. He calls it a "process of manifestation," in which programming leads to thoughts, thoughts lead to feelings, feelings lead to actions, and actions lead to results.

Such programming can be recognized and perhaps modified, in pursuit of specific personal goals. "That's why it is important," says Mr. Mikhaylov, "to identify your vision, draft a solid plan, and remain focused."

If you don't want to work with an advisor, there are things you can do on your own. As an example, you can have a conversation with your spouse in which you ask, "Why is money important to you?" If the answer is, "It can provide the things I want," you can ask, "What things do you want?" And so on. Eventually, you and your spouse will reach the point where you can visualize your financial goals. Once you've visualized your goals, you are more likely to realize them.

Start Where You Are

Of course, the first step in getting where you're going is knowing where you are—how much your lifestyle costs and a full reckoning of your financial obligations. For young physicians, this may mean taking a good look at student loans and credit card debt that was racked up during those lean medical school and residency years. It may also mean making decisions about childcare options. Along with those big-ticket items are nickel-and-dime expenditures that don't feel like much as you shell out $5 for a coffee and a muffin at Starbucks or a $25 take-out dinner, but may add up to a big obstacle to more important financial goals, such as home ownership, education expenses, and retirement.

"For young people, the most important area of financial planning is cash flow," says Charlie Taylor of Taylor & Padgett Financial Group, Prescott, Ariz. "We've been tracking spending for one client who told me that she spent more in June because she had birthday gifts to buy and weddings to attend. July had more birthdays and weddings; then she was taking a trip in August. Eventually she realized that each month is 'unusual' and she was always spending over her budget."

How does Mr. Taylor deal with such clients? "We talk about spending," he says. "Rather than classify spending as 'good' or 'bad,' we use 'good,' 'better,' and 'best.' Everyone has his or her own values, and we try to make sure that money is being spent on 'best' items."

Maintaining your lifestyle may be desirable, but keep in mind that money spent today can't be saved for the goals you've set for tomorrow. Financial visioning can be vital for young doctors with small children and the expenses that come with children, including childcare, tuition, and other expenses.

"I recently met with a 40-year-old surgeon, married to a part-time professor," says Marilyn Capelli Dimitroff of Capelli Financial Services in Bloomfield Hills, Mich. "They have three children under age six."

The surgeon will soon become a partner in his practice, so his income will increase dramatically. That will come in handy because the couple has a large mortgage, with little equity in the home, as well as outstanding student loans. On the positive side of the ledger, the couple has some cash in a money market fund, the wife has money in a 403(b) plan, and the surgeon receives partnership contributions to his account in a profit-sharing plan.

"They recently bought into a condo on the water with family members," says Ms. Dimitroff. "The surgeon's brother already owns the property. Our clients will own 1⁄3 and pay 1⁄3 of the expenses. When we began our financial visioning process, they had no idea how they stood, how to educate their kids, what or how to save, whether she needed to work, or if the condo was a good idea."

Ms. Dimitroff collected "hard data," as she puts it. "Then we explored in depth what they wanted to do, what was important to them, and what their attitudes were on a variety of issues," she says. "We then did an assessment of what would happen if their current financial practices continued without change: no education savings, a low level of investing, owning part of the condo, an increasing personal liability as partner in the medical group, current insurance coverages, and so on."

If you don't want to work with an advisor, there are things you can do on your own. As an example, you can have a conversation with your spouse in which you ask, "Why is money important to you?" If the answer is, "It can provide the things I want," you can ask, "What things do you want?" And so on. Eventually, you and your spouse will reach the point where you can visualize your financial goals.

This analysis showed that this couple would have little chance of meeting their goals. "They would be in trouble if one of them died or became disabled," says Ms. Dimitroff. "Their property/casualty/liability coverage would not protect them well, especially now that owning part of the condo opens them to significant exposure."

Moreover, the surgeon was not clear about the details of the partnership. "They had never considered asset protection," says Ms. Dimitroff, "and their wishes for their children would be unknown in the event they died." That is, this couple had no wills, so the decedent's assets would be distributed according to state law, not as they would have chosen, upon the death of either spouse.

In response, Ms. Dimitroff developed a strategy in each area. "We created a plan of action that brought the likelihood of their meeting their complete set of goals—including annual family vacations—into a comfort zone," she says. "We established an investing plan that includes after-tax, retirement, and college components, using available tax strategies. Our plan also brings insurance coverages to appropriate levels while we'll gather and use information on the partnership in order to reduce potential liability there."

The new plan addresses the issues posed by the condo, including costs and liability exposure. "It lays out a strategy for efficiently getting assets where they want them to go with minimal cost and time via estate documents," says Ms. Dimitroff. "We focused on naming appropriate beneficiaries in the event either of them dies. They now understand their situation on all fronts and know what they need to do. And they know they can do it.

"Although they are just beginning to make appropriate changes," Ms. Dimitroff adds, "we want this couple to have the comfort of knowing they are making informed and wise decisions.

For more on wills, see pages 102–109.

For more on paying back student loans, see pages 19–23.

For more on insurance coverage, see pages 68–76.

Values Activity: Values and Goals Questionnaire

Answer the following questions: If you live with someone else, think about how they might answer. Ask them to answer these questions, too. You may be surprised by what you will learn about each other.

- What are your greatest fears about money? What do you think might happen if you don't have enough?

Your response: ____________________

Your partner's response: ____________________

- What money topic often starts an argument within your family?

Your response: ____________________

Your partner's response: ____________________

- If you had to cut back on spending, what would you cut? How much could you save?

Your response: ____________________

Your partner's response: ____________________

- If you suddenly had $10,000, what would you do with it?

Your response: ____________________

Your partner's response: ____________________

- What was the poorest choice(s) you ever made about money? Why?

Your response: ____________________

Paying Off Student Debt

Even while physicians are planning their children's education, they may still be paying off their own student debts. According to FinAid.org, an online guide to educational aid based in Cranberry Township, Penn., 70% of undergraduates and post-graduates have outstanding debt, averaging $42,406 altogether. The percentages (90% and 95%) are higher for those who went through law or medical school and so are the totals: about $80,000 and $125,000, respectively. Moreover, those numbers are averages so some young doctors may be facing hundreds of thousands of dollars of debt.

"In the past few years, when interest rates were rising, consolidation was an easy choice," says Jeff Fishman, who heads JSF Financial, a planning firm in Los Angeles. "Now, that's a far more difficult decision."

For one reason, interest rates on these loans are capped at 8.25% by federal law. When loans are consolidated, the fixed

Your partner's response: ______________________________

- How has your attitude about money changed from childhood, or in the last three to five years?

Your response: ______________________________

Your partner's response: ______________________________

- What kind of things is a pleasure to buy?

Your response: ______________________________

Your partner's response: ______________________________

- What kind of things is not a pleasure to buy?

Your response: ______________________________

Your partner's response: ______________________________

- Do you think you are too tight with money, too free with money, or about right with your spending habits?

Your response: ______________________________

Your partner's response: ______________________________

- If you wanted to save money for some things that are important, what would they be?

Your response: ______________________________

Your partner's response: ______________________________

Personal Financial Choices, Visa USA 2007.

rate is the weighted average of the outstanding debt, rounded up to the nearest one-eighth of a percentage point. Therefore, consolidating a package of loans at the current 7.14% rate means locking in a rate at 7.25%, which is not far from the 8.25% cap. The current rate will be in effect until July 1, 2007.

> **According to FinAid.org,** an online guide to educational aid based in Cranberry Township, Pennsylvania, 70% of undergraduates and postgraduates have outstanding debt, averaging $42,406 altogether. The percentages (90% and 95%) are higher for those who went through law or medical school and so are the totals: about $80,000 and $125,000, respectively.

In addition, after federal student loans have been consolidated, the same package of loans cannot be refinanced if rates go lower. Historically, rates on student loans have averaged in the 6.4%- to 6.8%-range. Therefore, consolidating now and locking in a 7.25% rate may mean giving up a prime opportunity to get a lower rate in the future, if rates drop to the level of 2004, when they were only 3.42%.

Nevertheless, consolidating eligible loans may have advantages. Mr. Fishman points out that consolidating loans can extend the repayment period and thus reduce monthly payments. Many young doctors with outstanding debt also want to buy homes so reducing monthly obligations may make it easier to get a mortgage.

Consolidated student loans come with several payment options, such as graduated payments that start by requiring close to no interest and then step up every two years.

"We have not recommended graduated payments to our clients," says Mr. Fishman. "We like clients to have continuity in budgeting rather than having to step up payments in the future. Clients prefer to spend more as their income increases rather than making higher dept repayments."

Generally, federal student loans have 10-year repayment terms. Upon consolidation of loans over $7,500, payback stretches to at least 12 years while individuals with balances over $40,000 get 25-year repayment, and the maximum 30-year term goes to those owing $60,000 or more.

Extending a 10-year loan to 30 years may mean paying much more interest, but that's not necessarily the case. Federal student loans can be prepaid with no penalty. Therefore, you can trim a loan balance as earnings increase, if that fits in with your financial plan.

One strategy is to wait until June to make an educated decision on when to refinance. By then, you'll have an idea of how interest rates have moved. If rates are higher, consolidating loans at 7.25% before the June 30, 2007, deadline will be a money saver. On the other hand, if rates are lower, it will pay to wait until the second half of the year, when student loans can be refinanced at a better rate.

If refinancing at current rates turns out to make sense, the posted 7.25% number may be misleading because many lenders offer incentives that effectively lower that rate. Some lenders will take 0.25% to 0.35% off the 7.25% rate for borrowers who agree to have monthly payments made directly from a bank account.

In addition, some lenders will reduce the interest rate by 1.25% after a borrower makes 30 consecutive on-time payments. The bottom line is that a doctor who consolidates at the current 7.25% rate may actually be paying less than 6% in a few years.

Some lenders may offer more- or less-generous incentives; so it pays to shop around before consolidating. Thanks to federal legislation passed in June 2006, it's no longer necessary for graduates who borrowed from one lender to refinance with that lender.

When you shop around for lenders, check the fine print. With some lenders, "late" is one day, so you'll miss the chance to reduce your interest rate. Others might give you 15 days until you're counted as being late with a payment.

Physicians also should realize that it may be best not to consolidate all student loans. Some federal loans have low rates, and some have forgiveness provisions that would be lost in a consolidation. Loan-forgiveness opportunities might be offered to doctors through the National Health Service Corps, which encourages physicians to practice in regions that lack adequate healthcare. Moreover, some hospitals and private health care facilities recruit doctors by offering to pay down debt.

Some doctors have taken out private loans, which can't be included in federal consolidation programs. Private loans can be handled separately: kept in place, refinanced, or paid down. "One of our clients has consolidated outstanding private student loans at 9%," says Mr. Fishman. "Now he's making an aggressive effort to pay down that loan."

Thus, some physicians will have public and private loans, which might or might not have been consolidated. Planning for such debt should be done with an eye on your overall liabilities.

High-cost debt should be paid down first. If consolidating student loans reduces your monthly payments, the money saved can be used to pay off credit cards. Bankrate.com currently puts the average fixed interest rate on standard (non-premium) credit cards at 13.44%; so paying down those balances makes more sense than prepaying student loans.

When making prepayment decisions, you should look at the after-tax cost of debt. The interest on student loans may be deductible, but the tax deduction phases out with income between $50,000 and $65,000 (between $105,000 and $135,000 on joint returns). The amount of the deduction is capped each year at $2,500, which would provide only partial relief to a young physician paying over 7% interest on $125,000 in student loans.

A doctor who can deduct the interest would effectively enjoy a return around 5%, when prepaying a 7%+ student loan. Physi-

Values Activity: "I Won the Lottery"

Sometimes what you'd do with a windfall of cash may be more illuminating than how you spend money you earn. When the money is unexpected, you may feel more justified spending it on your dreams and wishes, rather than your needs and day-to-day expenses.

What would you do if you had an unexpected windfall? Name the first three things on which you would spend your money if you won the lottery:

1.____

2.____

3.____

Did you find that the items you listed here reflect the values you listed in Activity #1? How much time, money, and energy are spent on your first priority? Where are you spending most of your resources?

Source: Personal Financial Choices, Visa USA 2007.

cians who can't use the deduction would get an after-tax return equal to the loan's interest rate. Rather than prepaying a student loan, it might be refinanced from other sources.

"We've had clients who have refinanced their home, pulled out some of the equity, and used the cash to pay down student loans when interest rates were attractive," says Mr. Fishman. Besides the chance to cut debt repayments if rates are favorable, borrowing against a home may offer fully tax-deductible interest, regardless of your income.

Putting a Price on Your Lifestyle

Retirement planning is also enhanced when you have a realistic idea of what you'd like to do and how much it will cost. At Ms. Foord's firm, an income/expense summary is called the "Lifestyle Price Tag" because it incorporates today's lifestyle expenses as well as the future desires for spending. "So many people don't know what their lifestyle really costs," says Ms. Foord, "so they can't determine if they are financially independent and able to move beyond their current circumstances. They also aren't able to see if they have excess funds that they can spend on things that have seemed extravagant, while they are in the accumulation phase."

Ms. Foord finds no shortage of dreams among her clients. "Having more free time is a major goal for physicians these days," she says. "They want to take the kids or the grandkids (or both) on really nice vacations, and they want to go on such vacations themselves. They'd like to redo the house to be the way they would really like it to be." And so on.

"By calculating our Lifestyle Price Tag," says Ms. Foord, "clients can get rid of the doubt that plagues them when they don't know the cost of that lifestyle. Then they can make wise decisions about getting more free time, having more of what they really want, and donating money to things they care about."

Developing your own financial vision will take some time and careful thinking, experts say, but it's well worth the effort. "Our long-term clients who have been through the process tell us that the result is peace of mind," Ms. Dimitroff says.