Flextime Arrangements

So much for the 40-hour workweek. According to statistics from AMA, the average physician works more like 54 hours per week—and some physicians work considerably longer than that. Even those who genuinely love their work may find fifty-plus hour weeks more than they bargained for. Some may make the decision to cut back, without completely abandoning medicine.

Fast Facts

- *Finding the balance between work and family can be difficult. Women physicians may find useful information and support on the Website,* www.mommd.com. *Page 82*
- *Reducing hours can affect eligibility for important benefits like health insurance, retirement plans, and malpractice insurance. Physicians need to have a full financial plan before moving to part-time work. Page 84*
- *Time management makes part-time practice work. Experts advise working a few full days, rather than short days, to minimize the impact of commute time and "work creep." Page 86*

Although physicians in some specialties tend to work more hours than others, the average physician clocks significantly more than the standard five eight-hour days. Physicians in anesthesiology, obstetrics and gynecology, general surgery, and urology report averages above 60 hours per week. Dermatology, emergency medicine, and pathology doctors clock in on the low end, but still hover around 46 hours per week.

There are no definitive statistics on the subject, but many physicians choose to work part-time at some point during their

careers. Although some male physicians cut back their hours to devote more time to family, women physicians may be more likely to scale back when they begin to have children. Some continue to work less than full-time while their children are young. Forward-thinking residency programs are even beginning to allow physicians—women and men alike—to spread their training out over a longer period of time so that they can work fewer hours and still receive the comprehensive training they need.

In addition to caring for young children, there are a variety of other motivations for physicians to work part-time. Easing into retirement, pursuing additional education, and making time for entrepreneurial ventures top the list. Along with the obvious benefit of working a less-than-100-percent schedule—more free time—there are also some challenges. Earning less money is one, and there are a variety of logistical issues. More subtle challenges also come into play, including the reaction of colleagues when a physician makes the decision to work less.

Then there are the internal questions: If I opt for part-time, am I still a "real doctor"? Am I dedicated and serious about my career? Because I spent all this time and money on my education, shouldn't I make maximum use of it? Will I stay sharp and competent if I only work part-time?

Physicians who want more time for themselves or their children may have to (a) ignore judgments about what a physician "should" do, and (b) quiet their own nagging doubts.

Opportunities Outside Medicine

The time demands and emotional stress of full-time clinical practice can be daunting. For some physicians, the concern is less about the number of hours worked and more about having enough variety that they don't experience career burnout long before it's time to retire. If a physician's financial needs are such that he or she needs a full-time income but is craving something beyond face-to-face time with patients, one alternative is to cut back on direct patient care and pick up one or more other duties. Some physicians may choose to do this within their own organizations (by teaching, doing research, or taking on a management or administrative role); others may reduce the hours at the primary job and work elsewhere one or two days a week.

TOPAMAX Tablets and TOPAMAX Sprinkle Capsules are indicated for adults for the prophylaxis of migraine headache. The usefulness of TOPAMAX in the acute treatment of migraine headache has not been studied.

TOPAMAX is contraindicated in patients with a history of hypersensitivity to any component of this product.

IMPORTANT SAFETY INFORMATION

TOPAMAX has been associated with serious adverse events, including:

- Hyperchloremic, non-anion gap metabolic acidosis—lowering of bicarbonate levels in the blood. Measurement of baseline and periodic serum bicarbonate is recommended.
- Acute myopia and secondary angle-closure glaucoma—patients should be cautioned to seek medical attention if they experience blurred vision or ocular pain.
- Oligohidrosis and hyperthermia—decreased sweating and increased body temperature, especially in hot weather. The majority of reports have been in children.
- Cognitive/psychiatric side effects including cognitive dysfunction, psychiatric/behavioral disturbances including suicidal thoughts or behavior, and somnolence and fatigue.

  Most common adverse events associated with TOPAMAX 100 mg vs placebo were: paresthesia, 51% vs 6%; anorexia,* 15% vs 6%; fatigue, 15% vs 11%; nausea, 13% vs 8%; diarrhea, 11% vs 4%; weight decrease, 9% vs 1%; taste alteration, 8% vs 1%.

  The possibility of decreased contraceptive efficacy and increased breakthrough bleeding should be considered in patients taking combination oral contraceptive products with TOPAMAX.

  Patients should be instructed to maintain an adequate fluid intake in order to minimize the risk of renal stone formation.

*Anorexia is defined as loss of appetite.

Managing *Migraines*
may require more than a quick fix.

Ask how frequent, disruptive migraines may impact her both during and between attacks. Choose TOPAMAX to help reduce migraine frequency.[1,2]

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Important
Avoid confusion with Toprol-XL® (metoprolol succinate) by spelling out TOPAMAX® (topiramate) on your prescription. Toprol-XL is a registered trademark of the AstraZeneca group of companies.

Please see brief summary of full Prescribing Information on following pages.

References: 1. Silberstein SD, Neto W, Schmitt J, Jacobs D, for the MIGR-001 Study Group. Topiramate in migraine prevention: results of a large controlled trial. *Arch Neurol.* 2004;61:490-495. **2.** Brandes JL, Saper JR, Diamond M, et al, for the MIGR-002 Study Group. Topiramate for migraine prevention: a randomized controlled trial. *JAMA.* 2004;291:965-973.

Life shouldn't always revolve around migraines.

TOPAMAX® (topiramate) Tablets

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Together Rx Access

ORTHO-McNEIL NEUROLOGICS, Inc.

 July 2007 02M931BDR1

TOPAMAX®
(topiramate)
Tablets

TOPAMAX®
(topiramate capsules)
Sprinkle Capsules

Rx only

Brief Summary of Full Prescribing Information for Migraine. CLINICAL STUDIES FOR OTHER INDICATIONS WILL HAVE DIFFERING ADVERSE EVENTS AND SAFETY CONCERNS. PLEASE SEE FULL PI FOR THIS INFORMATION REGARDING TOPAMAX® FOR EPILEPSY.

INDICATIONS AND USAGE

Migraine: TOPAMAX® (topiramate) Tablets and TOPAMAX® (topiramate capsules) Sprinkle Capsules are indicated for adults for the prophylaxis of migraine headache. The usefulness of TOPAMAX® in the acute treatment of migraine headache has not been studied.

CONTRAINDICATIONS: TOPAMAX® is contraindicated in patients with a history of hypersensitivity to any component of this product.

WARNINGS: Metabolic Acidosis: Hyperchloremic, non-anion gap, metabolic acidosis (i.e., decreased serum bicarbonate below the normal reference range in the absence of chronic respiratory alkalosis) is associated with topiramate treatment. This metabolic acidosis is caused by renal bicarbonate loss due to the inhibitory effect of topiramate on carbonic anhydrase. Such electrolyte imbalance has been observed with the use of topiramate in placebo-controlled clinical trials and in the post-marketing period. Generally, topiramate-induced metabolic acidosis occurs early in treatment although cases can occur at any time during treatment. Bicarbonate decrements are usually mild-moderate (average decrease of 4 mEq/L at daily doses of 400 mg in adults and at approximately 6 mg/kg/day in pediatric patients); rarely, patients can experience severe decrements to values below 10 mEq/L. Conditions or therapies that predispose to acidosis (such as renal disease, severe respiratory disorders, status epilepticus, diarrhea, surgery, ketogenic diet, or drugs) may be additive to the bicarbonate lowering effects of topiramate. Metabolic acidosis has been observed at doses as low as 50 mg/day. Serum bicarbonate levels have not been systematically evaluated at daily doses greater than 400 mg/day. The incidence of persistent treatment-emergent decreases in serum bicarbonate in placebo-controlled trials for adults for prophylaxis of migraine was 44% for 200 mg/day, 39% for 100 mg/day, 23% for 50 mg/day, and 7% for placebo. The incidence of a markedly abnormally low serum bicarbonate (i.e., absolute value <17 mEq/L and >5 mEq/L decrease from pretreatment) in these trials was 11% for 200 mg/day, 9% for 100 mg/day, 2% for 50 mg/day, and <1% for placebo. Some manifestations of acute or chronic metabolic acidosis may include hyperventilation, nonspecific symptoms such as fatigue and anorexia, or more severe sequelae including cardiac arrhythmias or stupor. Chronic, untreated metabolic acidosis may increase the risk for nephrolithiasis or nephrocalcinosis, and may also result in osteomalacia (referred to as rickets in pediatric patients) and/or osteoporosis with an increased risk for fractures. Chronic metabolic acidosis in pediatric patients may also reduce growth rates. A reduction in growth rate may eventually decrease the maximal height achieved. The effect of topiramate on growth and bone-related sequelae has not been systematically investigated. Measurement of baseline and periodic serum bicarbonate during topiramate treatment is recommended. If metabolic acidosis develops and persists, consideration should be given to reducing the dose or discontinuing topiramate (using dose tapering). If the decision is made to continue patients on topiramate in the face of persistent acidosis, alkali treatment should be considered. **Acute Myopia and Secondary Angle Closure Glaucoma:** A syndrome consisting of acute myopia associated with secondary angle closure glaucoma has been reported in patients receiving TOPAMAX®. Symptoms include acute onset of decreased visual acuity and/or ocular pain. Ophthalmologic findings can include myopia, anterior chamber shallowing, ocular hyperemia (redness) and increased intraocular pressure. Mydriasis may or may not be present. This syndrome may be associated with supraciliary effusion resulting in anterior displacement of the lens and iris, with secondary angle closure glaucoma. Symptoms typically occur within 1 month of initiating TOPAMAX® therapy. In contrast to primary narrow angle glaucoma, which is rare under 40 years of age, secondary angle closure glaucoma associated with topiramate has been reported in pediatric patients as well as adults. The primary treatment to reverse symptoms is discontinuation of TOPAMAX® as rapidly as possible, according to the judgment of the treating physician. Other measures, in conjunction with discontinuation of TOPAMAX®, may be helpful. Elevated intraocular pressure of any etiology, if left untreated, can lead to serious sequelae including permanent vision loss. **Oligohidrosis and Hyperthermia:** Oligohidrosis (decreased sweating), infrequently resulting in hospitalization, has been reported in association with TOPAMAX® use. Decreased sweating and an elevation in body temperature above normal characterized these cases. Some of the cases were reported after exposure to elevated environmental temperatures. The majority of the reports have been in children. Patients, especially pediatric patients, treated with TOPAMAX® should be monitored closely for evidence of decreased sweating and increased body temperature, especially in hot weather. Caution should be used when TOPAMAX® is prescribed with other drugs that predispose patients to heat-related disorders; these drugs include, but are not limited to, other carbonic anhydrase inhibitors and drugs with anticholinergic activity. **Cognitive/Neuropsychiatric Adverse Events:** Adults: Adverse events most often associated with the use of TOPAMAX® were related to the central nervous system. In adults, the most frequent of these can be classified into three general categories: 1) Cognitive-related dysfunction (e.g., confusion, psychomotor slowing, difficulty with concentration/attention, difficulty with memory, speech or language problems, particularly word-finding difficulties); 2) Psychiatric/behavioral disturbances (e.g., depression or mood problems); and 3) Somnolence or fatigue. *Cognitive-Related Dysfunction:* The majority of cognitive-related adverse events were mild to moderate in severity, and they frequently occurred in isolation. Rapid titration rate and higher initial dose were associated with higher incidences of these events. Many of these events contributed to withdrawal from treatment (see **ADVERSE REACTIONS, Table 1**). In the 6-month migraine prophylaxis controlled trials using a slower titration regimen (25 mg/day weekly increments), the proportion of patients who experienced one or more cognitive-related adverse events was 19% for TOPAMAX® 50 mg/day, 22% for 100 mg/day, 28% for 200 mg/day, and 10% for placebo. These dose-related adverse reactions typically began in the titration phase and often persisted into the maintenance phase, but infrequently began in the maintenance phase. Some patients experienced a recurrence of one or more of these cognitive adverse events and this recurrence was typically in the titration phase. A relatively small proportion of topiramate-treated patients experienced more than one concurrent cognitive adverse event. The most common cognitive adverse events occurring together included difficulty with memory along with difficulty with concentration/attention, difficulty with memory along with language problems, and difficulty with concentration/attention along with language problems. Rarely, topiramate-treated patients experienced three concurrent cognitive events. *Psychiatric/Behavioral Disturbances:* Psychiatric/behavioral disturbances (depression or mood problems) were dose-related for both the epilepsy and migraine populations. In the double blind phases of clinical trials with topiramate in approved and investigational indications, suicide attempts occurred at a rate of 3/1000 patient years (13 events/3999 patient years) on topiramate versus 0 (0 events/1430 patient years) on placebo. One completed suicide was reported in a bipolar disorder trial in a patient on topiramate. *Somnolence/Fatigue:* Fatigue and somnolence were dose-related and more common in the titration phase.

PRECAUTIONS: Hyperammonemia and Encephalopathy Associated with Concomitant Valproic Acid Use: Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include

acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. Kidney Stones: As in the general population, the incidence of stone formation among topiramate treated patients was higher in men. Kidney stones have also been reported in pediatric patients. An explanation for the association of TOPAMAX® and kidney stones may lie in the fact that topiramate is a carbonic anhydrase inhibitor. Carbonic anhydrase inhibitors, e.g., acetazolamide or dichlorphenamide, promote stone formation by reducing urinary citrate excretion and by increasing urinary pH. The concomitant use of TOPAMAX® with other carbonic anhydrase inhibitors or potentially in patients on a ketogenic diet may create a physiological environment that increases the risk of kidney stone formation, and should therefore be avoided. Increased fluid intake increases the urinary output, lowering the concentration of substances involved in stone formation. Hydration is recommended to reduce new stone formation. Paresthesia: Paresthesia (usually tingling of the extremities), an effect associated with the use of other carbonic anhydrase inhibitors, appears to be a common effect of TOPAMAX®. Paresthesia was more frequently reported in the monotherapy epilepsy trials and migraine prophylaxis trials versus the adjunctive therapy epilepsy trials. In the majority of instances, paresthesia did not lead to treatment discontinuation. Adjustment of Dose in Renal Failure: The major route of elimination of unchanged topiramate and its metabolites is via the kidney. Dosage adjustment may be required in patients with reduced renal function (see **DOSAGE AND ADMINISTRATION** in the full PI). Decreased Hepatic Function: In hepatically impaired patients, topiramate should be administered with caution as the clearance of topiramate may be decreased. **Information for Patients:** Patients should be instructed to read the Patient Information before starting treatment with TOPAMAX® and each time their prescription is renewed. Patients taking TOPAMAX® should be told to seek immediate medical attention if they experience blurred vision, visual disturbances or periorbital pain. Patients, especially pediatric patients, treated with TOPAMAX® should be monitored closely for evidence of decreased sweating and increased body temperature, especially in hot weather. Patients, particularly those with predisposing factors, should be instructed to maintain an adequate fluid intake in order to minimize the risk of renal stone formation [see **PRECAUTIONS:** Kidney Stones, for support regarding hydration as a preventative measure]. Patients should be warned about the potential for somnolence, dizziness, confusion, difficulty concentrating, and visual effects and advised not to drive or operate machinery until they have gained sufficient experience on topiramate to gauge whether it adversely affects their mental performance, motor performance, and/or vision. Additional food intake may be considered if the patient is losing weight while on this medication. **Laboratory Tests:** Measurement of baseline and periodic serum bicarbonate during topiramate treatment is recommended (see **WARNINGS**). In double-blind trials hypokalemia defined as serum potassium decline below 3.5 mmol/L has been observed in 0.4% of subjects treated with topiramate compared to 0.1% of subjects treated with placebo. **Drug Interactions:** *In vitro* studies indicate that topiramate does not inhibit enzyme activity for CYP1A2, CYP2A6, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP2E1 and CYP3A4/5 isozymes. **Other Drug Interactions: Digoxin:** In a single-dose study, serum digoxin AUC was decreased by 12% with concomitant TOPAMAX® administration. The clinical relevance of this observation has not been established. **CNS Depressants:** Concomitant administration of TOPAMAX® and alcohol or other CNS depressant drugs has not been evaluated in clinical studies. Because of the potential of topiramate to cause CNS depression, as well as other cognitive and/or neuropsychiatric adverse events, topiramate should be used with extreme caution if used in combination with alcohol and other CNS depressants. **Oral Contraceptives:** In a pharmacokinetic interaction study in healthy volunteers with a concomitantly administered combination oral contraceptive product containing 1 mg norethindrone (NET) plus 35 mcg ethinyl estradiol (EE), TOPAMAX® given in the absence of other medications at doses of 50 to 200 mg/day was not associated with statistically significant changes in mean exposure (AUC) to either component of the oral contraceptive. In another study, exposure to EE was statistically significantly decreased at doses of 200, 400, and 800 mg/day (18%, 21%, and 30%, respectively) when given as adjunctive therapy in patients taking valproic acid. In both studies, TOPAMAX® (50 mg/day to 800 mg/day) did not significantly affect exposure to NET. Although there was a dose dependent decrease in EE exposure for doses between 200-800 mg/day, there was no significant dose dependent change in EE exposure for doses of 50-200 mg/day. The clinical significance of the changes observed is not known. The possibility of decreased contraceptive efficacy and increased breakthrough bleeding should be considered in patients taking combination oral contraceptive products with TOPAMAX®. Patients taking estrogen containing contraceptives should be asked to report any change in their bleeding patterns. Contraceptive efficacy can be decreased even in the absence of breakthrough bleeding. **Hydrochlorothiazide (HCTZ):** A drug-drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of HCTZ (25 mg q24h) and topiramate (96 mg q12h) when administered alone and concomitantly. The results of this study indicate that topiramate C_{max} increased by 27% and AUC increased by 29% when HCTZ was added to topiramate. The clinical significance of this change is unknown. The addition of HCTZ to topiramate therapy may require an adjustment of the topiramate dose. The steady-state pharmacokinetics of HCTZ were not significantly influenced by the concomitant administration of topiramate. Clinical laboratory results indicated decreases in serum potassium after topiramate or HCTZ administration, which were greater when HCTZ and topiramate were administered in combination. **Metformin:** A drug-drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of metformin and topiramate in plasma when metformin was given alone and when metformin and topiramate were given simultaneously. The results of this study indicated that metformin mean C_{max} and mean $AUC_{0\text{-}12h}$ increased by 18% and 25%, respectively, while mean CL/F decreased 20% when metformin was co-administered with topiramate. Topiramate did not affect metformin t_{max}. The clinical significance of the effect of topiramate on metformin pharmacokinetics is unclear. Oral plasma clearance of topiramate appears to be reduced when administered with metformin. The extent of change in the clearance is unknown. The clinical significance of the effect of metformin on topiramate pharmacokinetics is unclear. When TOPAMAX® is added or withdrawn in patients on metformin therapy, careful attention should be given to the routine monitoring for adequate control of their diabetic disease state. **Pioglitazone:** A drug-drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of topiramate and pioglitazone when administered alone and concomitantly. A 15% decrease in the $AUC_{\tau,ss}$ of pioglitazone with no alteration in $C_{max,ss}$ was observed. This finding was not statistically significant. In addition, a 13% and 16% decrease in $C_{max,ss}$ and $AUC_{\tau,ss}$ respectively, of the active hydroxy-metabolite was noted as well as a 60% decrease in $C_{max,ss}$ and $AUC_{\tau,ss}$ of the active keto-metabolite. The clinical significance of these findings is not known. When TOPAMAX® is added to pioglitazone therapy or pioglitazone is added to TOPAMAX® therapy, careful attention should be given to the routine monitoring of patients for adequate control of their diabetic disease state. **Lithium:** Multiple dosing of topiramate 100 mg every 12 hrs decreased the AUC and C_{max} of Lithium (300 mg every 8 hrs) by 20% (N=12, 6 M; 6 F). **Haloperidol:** The pharmacokinetics of a single dose of haloperidol (5 mg) were not affected following multiple dosing of topiramate (100 mg every 12 hr) in 13 healthy

adults (6 M, 7 F). **Amitriptyline:** There was a 12% increase in AUC and C_{max} for amitriptyline (25 mg per day) in 18 normal subjects (9 male; 9 female) receiving 200 mg/day of topiramate. Some subjects may experience a large increase in amitriptyline concentration in the presence of topiramate and any adjustments in amitriptyline dose should be made according to the patient's clinical response and not on the basis of plasma levels. **Sumatriptan:** Multiple dosing of topiramate (100 mg every 12 hrs) in 24 healthy volunteers (14 M, 10 F) did not affect the pharmacokinetics of single dose sumatriptan either orally (100 mg) or subcutaneously (6 mg). **Risperidone:** There was a 25% decrease in exposure to risperidone (2 mg single dose) in 12 healthy volunteers (6 M, 6 F) receiving 200 mg/day of topiramate. Therefore, patients receiving risperidone in combination with topiramate should be closely monitored for clinical response. **Propranolol:** Multiple dosing of topiramate (200 mg/day) in 34 healthy volunteers (17 M, 17 F) did not affect the pharmacokinetics of propranolol following daily 160 mg doses. Propranolol doses of 160 mg/day in 39 volunteers (27M, 12F) had no effect on the exposure to topiramate at a dose of 200 mg/day of topiramate. **Dihydroergotamine:** Multiple dosing of topiramate (200 mg/day) in 24 healthy volunteers (12 M, 12 F) did not affect the pharmacokinetics of a 1 mg subcutaneous dose of dihydroergotamine. Similarly, a 1 mg subcutaneous dose of dihydroergotamine did not effect the pharmacokinetics of a 200 mg/day dose of topiramate in the same study. **Others:** Concomitant use of TOPAMAX®, a carbonic anhydrase inhibitor, with other carbonic anhydrase inhibitors, e.g., acetazolamide or dichlorphenamide, may create a physiological environment that increases the risk of renal stone formation, and should therefore be avoided. **Drug/Laboratory Tests Interactions:** There are no known interactions of topiramate with commonly used laboratory tests. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** An increase in urinary bladder tumors was observed in mice given topiramate (20, 75, and 300 mg/kg) in the diet for 21 months. The elevated bladder tumor incidence, which was statistically significant in males and females receiving 300 mg/kg, was primarily due to the increased occurrence of a smooth muscle tumor considered histomorphologically unique to mice. Plasma exposures in mice receiving 300 mg/kg were approximately 0.5 to 1 times steady-state exposures measured in patients receiving topiramate monotherapy at the recommended human dose (RHD) of 400 mg, and 1.5 to 2 times steady-state topiramate exposures in patients receiving 400 mg of topiramate plus phenytoin. The relevance of this finding to human carcinogenic risk is uncertain. No evidence of carcinogenicity was seen in rats following oral administration of topiramate for 2 years at doses up to 120 mg/kg (approximately 3 times the RHD on a mg/m^2 basis). Topiramate did not demonstrate genotoxic potential when tested in a battery of *in vitro* and *in vivo* assays. Topiramate was not mutagenic in the Ames test or the *in vitro* mouse lymphoma assay; it did not increase unscheduled DNA synthesis in rat hepatocytes *in vitro;* and it did not increase chromosomal aberrations in human lymphocytes *in vitro* or in rat bone marrow *in vivo.* No adverse effects on male or female fertility were observed in rats at doses up to 100 mg/kg (2.5 times the RHD on a mg/m^2 basis). **Pregnancy: Pregnancy Category C.** Topiramate has demonstrated selective developmental toxicity, including teratogenicity, in experimental animal studies. When oral doses of 20, 100, or 500 mg/kg were administered to pregnant mice during the period of organogenesis, the incidence of fetal malformations (primarily craniofacial defects) was increased at all doses. The low dose is approximately 0.2 times the recommended human dose (RHD=400 mg/day) on a mg/m^2 basis. Fetal body weights and skeletal ossification were reduced at 500 mg/kg in conjunction with decreased maternal body weight gain. In rat studies (oral doses of 20, 100, and 500 mg/kg or 0.2, 2.5, 30, and 400 mg/kg), the frequency of limb malformations (ectrodactyly, micromelia, and amelia) was increased among the offspring of dams treated with 400 mg/kg (10 times the RHD on a mg/m^2 basis) or greater during the organogenesis period of pregnancy. Embryotoxicity (reduced fetal body weights, increased incidence of structural variations) was observed at doses as low as 20 mg/kg (0.5 times the RHD on a mg/m^2 basis). Clinical signs of maternal toxicity were seen at 400 mg/kg and above, and maternal body weight gain was reduced during treatment with 100 mg/kg or greater. In rabbit studies (20, 60, and 180 mg/kg or 10, 35, and 120 mg/kg orally during organogenesis), embryo/fetal mortality was increased at 35 mg/kg (2 times the RHD on a mg/m^2 basis) or greater, and teratogenic effects (primarily rib and vertebral malformations) were observed at 120 mg/kg (6 times the RHD on a mg/m^2 basis). Evidence of maternal toxicity (decreased body weight gain, clinical signs, and/or mortality) was seen at 35 mg/kg and above. When female rats were treated during the latter part of gestation and throughout lactation (0.2, 4, 20, and 100 mg/kg or 2, 20, and 200 mg/kg), offspring exhibited decreased viability and delayed physical development at 200 mg/kg (5 times the RHD on a mg/m^2 basis) and reductions in pre- and/or postweaning body weight gain at 2 mg/kg (0.05 times the RHD on a mg/m^2 basis) and above. Maternal toxicity (decreased body weight gain, clinical signs) was evident at 100 mg/kg or greater. In a rat embryo/fetal development study with a postnatal component (0.2, 2.5, 30, or 400 mg/kg during organogenesis; noted above), pups exhibited delayed physical development at 400 mg/kg (10 times the RHD on a mg/m^2 basis) and persistent reductions in body weight gain at 30 mg/kg (1 times the RHD on a mg/m^2 basis) and higher. There are no studies using TOPAMAX® in pregnant women. TOPAMAX® should be used during pregnancy only if the potential benefit outweighs the potential risk to the fetus. In post-marketing experience, cases of hypospadias have been reported in male infants exposed in utero to topiramate, with or without other anticonvulsants; however, a causal relationship with topiramate has not been established. **Labor and Delivery:** In studies of rats where dams were allowed to deliver pups naturally, no drug-related effects on gestation length or parturition were observed at dosage levels up to 200 mg/kg/day. The effect of TOPAMAX® on labor and delivery in humans is unknown. **Nursing Mothers:** Topiramate is excreted in the milk of lactating rats. The excretion of topiramate in human milk has not been evaluated in controlled studies. Limited observations in patients suggest an extensive secretion of topiramate into breast milk. Since many drugs are excreted in human milk, and because the potential for serious adverse reactions in nursing infants to TOPAMAX® is unknown, the potential benefit to the mother should be weighed against the potential risk to the infant when considering recommendations regarding nursing. **Pediatric Use:** Topiramate is associated with metabolic acidosis. Chronic untreated metabolic acidosis in pediatric patients may cause osteomalacia/rickets and may reduce growth rates. A reduction in growth rate may eventually decrease the maximal height achieved. The effect of topiramate on growth and bone-related sequelae has not been systematically investigated (see **WARNINGS**). Safety and effectiveness in pediatric patients have not been established for the prophylaxis treatment of migraine headache. **Geriatric Use:** In clinical trials, 3% of patients were over 60. No age related difference in effectiveness or adverse effects were evident. However, clinical studies of topiramate did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently than younger subjects. Dosage adjustment may be necessary for elderly with impaired renal function (creatinine clearance rate ≤ 70 mL/min/1.73 m^2) due to reduced clearance of topiramate (see **CLINICAL PHARMACOLOGY** and **DOSAGE AND ADMINISTRATION** in the full PI). **Race and Gender Effects:** Evaluation of effectiveness and safety in clinical trials has shown no race or gender related effects.

ADVERSE REACTIONS: The data described in the following section were obtained using TOPAMAX® (topiramate) Tablets. **Migraine:** In the four multicenter, randomized, double-blind, placebo-controlled, parallel group migraine prophylaxis clinical trials, most of the adverse events with topiramate were mild or moderate in severity. Most adverse events occurred more frequently during the titration period than during the maintenance period. Table 1 includes those adverse events reported for patients in the placebo-controlled trials where the incidence rate in any topiramate treatment group was at least 2% and was greater than that for placebo patients.

Table 1: Incidence of Treatment-Emergent Adverse Events in Placebo-Controlled, Migraine Trials Where Rate Was ≥ 2% in Any

Topiramate Group and Greater than the Rate in Placebo-Treated Patients.[a] **Body System/**Adverse Event followed by Placebo (N=445) first, TOPAMAX® Dosage (mg/day) 50 (N=235) second, 100 (N=386) third, 200 (N=514) fourth. **Body as a Whole – General Disorders:** Fatigue 11, 14, 15, 19; Injury 7, 9, 6, 6; Asthenia 1, <1, 2, 2; Fever 1, 1, 1, 2; Influenza-Like Symptoms <1, <1, <1, 2; Allergy <1, 2, <1, <1; **Central & Peripheral Nervous System Disorders:** Paresthesia 6, 35, 51, 49; Dizziness 10, 8, 9, 12; Hypoaesthesia 2, 6, 7, 8; Language Problems 2, 7, 6, 7; Involuntary Muscle Contractions 1, 2, 2, 4; Ataxia <1, 1, 2, 1; Speech Disorders/Related Speech Problems <1, 1, <1, 2; **Gastro-Intestinal System Disorders:** Nausea 8, 9, 13, 14; Diarrhea 4, 9, 11, 11; Abdominal Pain 5, 6, 6, 7; Dyspepsia 3, 4, 5, 3; **Gastro-Intestinal System Disorders:** Dry Mouth 2, 2, 3, 5; Vomiting 2, 1, 2, 3; Gastroenteritis 1, 3, 3, 2; **Hearing and Vestibular Disorders:** Tinnitus 1, <1, 1, 2; **Metabolic and Nutritional Disorders:** Weight Decrease 1, 6, 9, 11; Thirst <1, 2, 2, 1; **Musculoskeletal System Disorders:** Arthralgia 2, 7, 3, 1; **Neoplasms:** Neoplasm NOS <1, 2, <1, <1; **Psychiatric Disorders:** Anorexia 6, 9, 15, 14; Somnolence 5, 8, 7, 10; Difficulty with Memory NOS 2, 7, 7, 11; Difficulty with Concentration/Attention 2, 3, 6, 10; Insomnia 5, 6, 7, 6; Anxiety 3, 4, 5, 6; Mood Problems 2, 3, 6, 5; Depression 4, 3, 4, 6; Nervousness 2, 4, 4, 4; Confusion 2, 2, 3, 4; Psychomotor Slowing 1, 3, 2, 4; Libido Decreased 1, 1, 1, 2; Aggravated Depression 1, 1, 2, 2; Agitation 1, 2, 2, 1; Cognitive Problems NOS 1, <1, 2, 2; **Reproductive Disorders, Female:** Menstrual Disorder 2, 3, 2, 2; **Reproductive Disorders, Male:** Ejaculation Premature 0, 3, 0, 0; **Resistance Mechanism Disorders:** Viral Infection 3, 4, 4, 3; Otitis Media <1, 2, 1, 1; **Respiratory System Disorders:** Upper Respiratory Tract Infection 12, 13, 14, 12; Sinusitis 6, 10, 6, 8; Pharyngitis 4, 5, 6, 2; Coughing 2, 2, 4, 3; Bronchitis 2, 3, 3, 3; Dyspnea 2, 1, 3, 2; Rhinitis 1, 1, 2, 2; **Skin and Appendages Disorders:** Pruritis 2, 4, 2, 2; **Special Sense Other, Disorders:** Taste Perversion 1, 15, 8, 12; Taste Loss <1, 1, 1, 2; **Urinary System Disorders:** Urinary Tract Infection 2, 4, 2, 4: Renal Calculus 0, 0, 1, 2; **Vision Disorders:** Vision Abnormal <1, 1, 2, 3; Blurred Vision[b] 2, 4, 2, 4; Conjunctivitis 1, 1, 2, 1: [a]Values represent the percentage of patients reporting a given adverse event. Patients may have reported more than one adverse event during the study and can be included in more than one adverse event category. [b]Blurred vision was the most common term considered as vision abnormal. Blurred vision was an included term that accounted for > 50% of events coded as vision abnormal, a preferred term. Of the 1,135 patients exposed to topiramate in the placebo-controlled studies, 25% discontinued due to adverse events, compared to 10% of the 445 placebo patients. The adverse events associated with discontinuing therapy in the topiramate-treated patients included paresthesia (7%), fatigue (4%), nausea (4%), difficulty with concentration/attention (3%), insomnia (3%), anorexia (2%), and dizziness (2%). Patients treated with topiramate experienced mean percent reductions in body weight that were dose-dependent. This change was not seen in the placebo group. Mean changes of 0%, -2%, - 3%, and - 4% were seen for the placebo group, topiramate 50, 100, and 200 mg groups, respectively. Table 2 shows adverse events that were dose-dependent. Several central nervous system adverse events, including some that represented cognitive dysfunction, were dose-related. The most common dose-related adverse events were paresthesia, fatigue, nausea, anorexia, dizziness, difficulty with memory, diarrhea, weight decrease, difficulty with concentration/attention, and somnolence.

Table 2: Incidence (%) of Dose-Related Adverse Events From Placebo-Controlled, Migraine Trials.[a] Adverse Event followed by Placebo (N=445) first, TOPAMAX® Dosage (mg/day) 50 (N=235) second, 100 (N=386) third, 200 (N=514) fourth. Paresthesia 6, 35, 51, 49; Fatigue 11, 14, 15, 19; Nausea 8, 9, 13, 14; Anorexia 6, 9, 15, 14; Dizziness 10, 8, 9, 12; Weight decrease 1, 6, 9, 11; Difficulty with Memory NOS 2, 7, 7, 11; Diarrhea 4, 9, 11, 11; Difficulty with Concentration/Attention 2, 3, 6, 10; Somnolence 5, 8, 7, 10; Hypoaesthesia 2, 6, 7, 8; Anxiety 3, 4, 5, 6; Depression 4, 3, 4, 6; Mood Problems 2, 3, 6, 5; Dry Mouth 2, 2, 3, 5; Confusion 2, 2, 3, 4; Involuntary Muscle Contractions 1, 2, 2, 4; Abnormal Vision <1, 1, 2, 3; Renal Calculus 0, 0, 1, 2. [a]The incidence rate of the adverse event in the 200 mg/day group was ≥ 2% than the rate in both the placebo group and the 50 mg/day group.

Other Adverse Events Observed During Migraine Clinical Trials: Topiramate, for the treatment of prophylaxis of migraine headache, has been administered to 1,367 patients in all clinical studies (includes double-blind and open-label extension). During these studies, all adverse events were recorded by the clinical investigators using terminology of their own choosing. To provide a meaningful estimate of the proportion of individuals having adverse events, similar types of events were grouped into a smaller number of standardized categories using modified WHOART dictionary terminology. The following additional adverse events that were not described earlier were reported by greater than 1% of the 1,367 topiramate-treated patients in the controlled clinical trials: **Body as a Whole:** Pain, chest pain, allergic reaction. **Central & Peripheral Nervous System Disorders:** Headache, vertigo, tremor, sensory disturbance, migraine aggravated. **Gastrointestinal System Disorders:** Constipation, gastroesophageal reflux, tooth disorder. **Musculoskeletal System Disorders:** Myalgia. **Platelet, Bleeding, and Clotting Disorders:** Epistaxis. **Reproductive Disorders, Female:** Intermenstrual bleeding. **Resistance Mechanism Disorders:** Infection, genital moniliasis. **Respiratory System Disorders:** Pneumonia, asthma. **Skin and Appendages Disorders:** Rash, alopecia. **Vision Disorders:** Abnormal accommodation, eye pain. **Postmarketing and Other Experience:** In addition to the adverse experiences reported during clinical testing of TOPAMAX®, the following adverse experiences have been reported worldwide in patients receiving TOPAMAX® post-approval. These adverse experiences have not been listed above and data are insufficient to support an estimate of their incidence or to establish causation. The listing is alphabetized: bullous skin reactions (including erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis), hepatic failure (including fatalities), hepatitis, pancreatitis, pemphigus, and renal tubular acidosis.

DRUG ABUSE AND DEPENDENCE: The abuse and dependence potential of TOPAMAX® has not been evaluated in human studies.

OVERDOSAGE

Overdoses of TOPAMAX® have been reported. Signs and symptoms included convulsions, drowsiness, speech disturbance, blurred vision, diplopia, mentation impaired, lethargy, abnormal coordination, stupor, hypotension, abdominal pain, agitation, dizziness and depression. The clinical consequences were not severe in most cases, but deaths have been reported after poly-drug overdoses involving TOPAMAX®.

Topiramate overdose has resulted in severe metabolic acidosis (see **WARNINGS**).

A patient who ingested a dose between 96 and 110 g topiramate was admitted to hospital with coma lasting 20-24 hours followed by full recovery after 3 to 4 days.

In acute TOPAMAX® overdose, if the ingestion is recent, the stomach should be emptied immediately by lavage or by induction of emesis. Activated charcoal has been shown to adsorb topiramate *in vitro*. Treatment should be appropriately supportive. Hemodialysis is an effective means of removing topiramate from the body.

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Physicians looking for career diversity may consider possibilities outside the realm of medicine. That option has worked out well for Glenn Miya, MD, an internist/pediatrician in the Los Angeles area. He has successfully combined his interest in writing and media with his dedication to medicine. Dr. Miya worked with physician career coach Peter Moskowitz, MD, to develop his dual career. "It takes a lot of thinking, talking it over, writing things down, self-inspection, and homework," says Dr. Miya.

"First I volunteered to answer phones at NPR [National Public Radio] in Pasadena. A year and a half later, I asked to join their internship program," says Dr. Miya. He asked the station not to give him any special consideration because he was a doctor, and they honored his request. "I was put alongside their college interns. They gave me projects. I served coffee. I did a lot of research. Of course the medical stories were easier, but there is not a lot of demand for medical stories." Eventually, Dr. Miya got to produce some of his own shows.

Today Dr. Miya is a paid health commentator and medical program producer at a public radio and television station in San Bernardino, Calif. For a long time Dr. Miya kept his journalism life private, but that didn't last once he was on the airwaves. "In the beginning I never mentioned it to my colleagues. But later, my staff heard me on the radio, and then patients, too." What Dr. Miya feared might be viewed as detracting from his primary work as a physician turned out to actually add credibility. "It complements medicine," says Dr. Miya. "A doctor's responsibility is to provide clear information; and for me, journalism and medicine are both part of educating others."

In addition to working four days a week in his medical practice and doing radio and television work, Dr. Miya writes, a talent and passion he first discovered in the fifth grade. He takes physical fitness seriously and has a busy family life. "It's not a matter of managing time, it's about managing energy," says Dr. Miya. He recounts a conversation he had with one of his instructors during his first year of medical school. The professor told him to put his schoolwork first and everything else second. "I did that, and he was right. But at some point you have to let go of that philosophy and get back to a balanced life."

Physicians thinking of exploring interests outside of medicine

may worry about what other people, particularly their peers, might think. "As doctors, we have already made so many sacrifices to be in our profession that it seems sacrilegious to consider veering away from it," says Dr. Miya. "When doctors explore anything outside of medicine, the perception is that they have less than 100 percent commitment to medicine."

Dr. Miya's career coach, Dr. Moskowitz, explains that when a physician contemplates a transition away from patient care, very few people may understand the decision. "It's important that a coach prepare a physician for the reality that people will question his or her sanity," says Dr. Moskowitz. "Others will be critical because, in fact, they're jealous. Those jealous ones are in the doldrums, but in denial. When they see a friend or colleague making a step to improve their happiness, they feel resentful." Dr. Moskowitz says that taking a step such as the one Dr. Miya took is challenging and requires great courage.

"As doctors, we have already made so many sacrifices to be in our profession that it seems sacrilegious to consider veering away from it," says Dr. Miya. "When doctors explore anything outside of medicine, the perception is that they have less than 100 percent commitment to medicine or that they're dissatisfied."

Dr. Miya suggests that physicians considering a career to complement the practice of medicine take a serious look at their underlying passions, evaluate why they went into medicine, and determine if they can keep up enthusiasm for both occupations intact. "Any doctor looking into a second profession must realize that most jobs don't have a singular path. In medicine, you must finish college, do well on the MCATs, complete medical school, then residency. In other jobs, experience, personality, industry contacts, and chutzpah can make a difference," he says.

In Dr. Miya's view, taking on a second career is, in some ways, like starting all over. "I remember the first time one of my producers harshly criticized my work. I felt like a neophyte medical student again. Having an MD doesn't necessarily catapult you into your second career," says Dr. Miya. "Be humble. Be grateful. Work hard." Starting over has paid off for Dr. Miya. "I'm working less, earning more, and have more satisfaction by having a second profession. One job enlivens the other."

Part-time Opportunities

Once a physician makes the decision to scale back to part-time, the question becomes how to do it. Physicians may have to get creative to come up with their own plan. Some physicians may be able to cut down while continuing in their current practices. For those with a full patient load, reducing hours or days at the office may need to be done gradually so as not to overburden colleagues. For solo physicians or those in a small group, a good first step might be to close the practice to new patients or, with proper notice, to stop participating in some insurance plans.

Job-sharing is one alternative—and not an uncommon one for husband-wife physician teams and physicians who have young children. If more than one physician in an office are considering a switch to part-time, it may be possible to work out sharing and cross-coverage arrangements with other doctors.

But often physicians will have to look outside their current situation. Here again, it pays to think outside the box.

Making Part-time Possible

Physicians who are clear on their reasons for working less than full-time, and who have made the decision to do just that, may find any number of ways to make it happen. Some include the following:

- Stay in the current practice and reduce the number of hours/days seeing patients.
- Locate an entirely new position that is part-time from the start.
- Do per diem or shift work in an urgent-care or community clinic.
- Work locum tenens and see the country (or the world).
- Do seasonal work or become a cruise ship doctor.
- Surgeons: scale back to surgical assisting only.
- OB/GYNs: discontinue the obstetrics and/or limit to practicing office-based care.
- Work part-time as the medical director at a nursing home or assisted living facility.
- Stop clinical practice altogether in favor of a part-time administrative role.
- Start a business—related or unrelated to medicine.

Patrick C. Alguire, MD, FACP, Director of Education and Career Development with the American College of Physicians (ACP), encourages physicians seeking part-time work to look beyond what the employment ad in the back of the journal says. "Don't be confined by the traditional rules," he says. "Go there with an offer and see what you can negotiate." An organization or community experiencing a shortage of physicians may be more open to negotiating a part-time position—even when their first preference might be to have a full-time employee.

Phyllis Stein of Cambridge, Mass., has been counseling professionals on career matters since 1976 and has been working with physicians since the early 1980s. She's also in favor of physicians negotiating for what they want. If part-time is the goal, she encourages physicians to make that desire known. "When you interview, you say, 'I'm very excited about this and would be even more excited if we could make it part-time.' Expect them to say no, but at least you've put the issue on the table." Ms. Stein also suggests that physicians make themselves indispensable on the job so that when they eventually request cutting back to part-time, the group or employer will make it happen rather than lose a valuable player.

Family and Medicine: Finding the Balance

Ms. Stein says she's seeing in medicine today—especially with women—what she saw in the legal profession twenty years ago. Popular legal dramas on television often give vivid portrayals of the demands young attorneys face when moving from humble associate to powerful partner in a firm. In many medical practices the pressure can be just as great, and Ms. Stein says the dilemma young physicians face when it comes to balancing work and family life is very similar to that of the young attorneys she counseled two decades ago.

While physicians may view this as their own challenge, it can pay to trade stories and strategies with others in similar positions. This is particularly true of female physicians, says Ms. Stein. "Every physician is struggling as if it's her own issue," says Ms. Stein. "Each woman thinks she has to solve the work-life balance problem by herself." She suggests that physicians talk to one another and work collectively to come up with cre-

ative solutions, rather than go it alone. She points out that shift work is popular with physicians who want to work part-time, or even full-time but with more control over their off hours.

A resource that women physicians with children may find useful is the Website, www.mommd.com. It boasts discussion forums, blogs, articles, job boards, and other information that can support and inspire women who are balancing medicine and family life.

Faryal Brousseau Michaud, DO, of Phoenix, Ariz., loves practicing medicine and teaching residents. She worked right up until the day she delivered her first baby, and she knew she wanted to continue her role as an academic hospitalist at St. Joseph's Medical Center after her maternity leave. "I took three months off and came back to work," says Dr. Michaud. But she also knew she wanted more time with her family.

After a couple of months, she observed a situation at her institution that allows her to have the best of both worlds—staying fully engaged in the work she's dedicated to and having plenty of time with both the baby and her husband. "We had a faculty shortage, and they were trying to lighten the weekend call." Dr. Michaud went to the program director and volunteered to be the weekend physician.

From Friday evening until mid-morning on Monday, she's on beeper call. She doesn't have to be at the hospital around the clock, but has to be ready to respond at any moment. "It's excellent for me," she says. "I keep my skills up, and my husband

Perfect Timing?

Faryal Brousseau Michaud, DO, of Phoenix, Ariz., says that for a physician, there's no ideal time to have a baby. Like many of her colleagues, she put off motherhood until she finished training. "It's very individualized," she says about the choice to start a family. "If that's the decision you want to make . . . it's such an incredible priority in your life that you'll make everything work." Dr. Michaud points out that women with far fewer resources than physicians figure out how to balance work and family. The only downside, she notes, is that she now has less time for herself, that she's stretched thin, but says "the reward on the other end is worth it."

spends the whole weekend with our daughter—without someone watching over his shoulder." Dr. Michaud's husband, an analytical chemist at Arizona State University, has enough flexibility that the schedule works for both of them. Dr. Michaud also credits her program director, who agreed to her idea.

Stacia Dearmin, MD, of Cleveland Heights, Oh., knew early in her medical school years that caring for children was her calling. Her first job as a physician was in a large pediatric practice. "It was a wonderful group," recalls Dr. Dearmin, "but the hours were a little overwhelming. Pediatrics is a field where work can bleed over into personal time—the beeper, hospital rounds, phone calls at the end of the day."

> **"When my older child** turned six, I thought 'six times three is eighteen – he'll be gone before I know it!'" Dr. Dearmin says. "But with the time we spend together now, I don't have that feeling of surprise with each birthday. I feel I know where the time went. I was there."

Dr. Dearmin and her husband, a professional guitarist, have two young sons. Working in general pediatrics, Dr. Dearmin says, "I began to see that my patients had more of my time and continuity of care than my own boys did. That was untenable to me. There are lots of pediatricians out there, but my boys only get one mother and one father." Looking for a less hectic pace, she and another physician started a small practice. Dr. Dearmin also moonlighted in a pediatric emergency department to make ends meet. About a year into this, the new practice situation was not working out as well as Dr. Dearmin had hoped. She realized it was time to reevaluate things—in her career and at home.

Dr. Dearmin decided to leave private practice in favor of working part-time in emergency pediatrics—a decision she did not take lightly. "It was an adjustment when I went part-time," she says. "I was going to sever many relationships I'd built with families over the course of quite a few years and provide acute care rather than ongoing care. That was a huge change in how I viewed my role in the world."

One of Dr. Dearmin's main concerns about going part-time was whether she would be able to get enough emergency department shifts to make this new way of practicing financially

viable. She now consistently works 30 to 32 hours a week in two different hospitals and schedules her time to meet the needs of her family. She works evenings and weekend shifts and takes time off for vacations, special events, and religious holidays. "A huge benefit for me is that this is shift work," says Dr. Dearmin. "It begins and ends at a predictable hour, and I'm paid for every minute I'm there."

The predictable schedule has other benefits: "It's allowed me to give back to medicine in other ways," she says. For example,

Before Taking the Plunge

Those looking at cutting back their work hours should make sure their financial house is in order before taking the plunge and cutting their income. Here are some steps recommended by financial experts and career coaches:

Meet with a financial planner and/or accountant. A fee-only certified financial planner or CPA is a good choice to help educate and help organize finances to ease the transition to part-time or contract work. Physicians will need to take a close look at taxes, insurance, debt management, retirement planning, and (if they have young dependents) college savings plans. Those who are not already investment-savvy may want to gain at least some basic knowledge before meeting with a financial planner. Some good sources are books on personal finance and retirement planning (just avoid the ones that lead you to believe that there really is a way to "get rich quick" or to beat the market). Many physicians enjoy the educational and humorous advice column, "The Motley Fool," which is syndicated in about 200 newspapers. Motley Fool's founding brothers David and Tom Gardner also have a radio program on NPR, and their Website (*www.fool.com*) offers excellent information.

Pay down or pay off debt. With the exception of school loans, a mortgage, and maybe a car payment, there is really no reason for a physician to carry debt. Of course, most physicians will have a credit card or two; but if balances are not being paid off at the end of each month, it's time to re-assess financial priorities, spending habits, and money management skills.

Set aside money for emergencies. Most financial gurus recommend having at least six months' living expenses readily available (i.e., in a savings or money market account, not tied up in real estate or

she now has time to teach pediatric advanced life support classes to other physicians and nurses.

Working part-time also allows Dr. Dearmin one luxury she'd never have considered when she was in private practice: She and her husband educate their children at home. "My younger son especially learns by getting his hands into things. We spend our mornings learning . . . about all sorts of subjects that are of interest to them and subjects that my husband and I feel they have to know to be well equipped." Educating children at home is a big

long-term investments) in case of interruptions in regular work or income. This makes a lot of sense and can provide peace of mind.

Set up a retirement plan. A financial planner or accountant can help with this. It's not all that complicated. Where most physicans will likely want advice is in deciding what to invest in once the retirement account is open. No-load, high-quality mutual funds are a good option for many people. The planner can also discuss risk tolerance and the importance of diversification.

Secure health insurance. Physicians who have a spouse or partner who works full-time and has health insurance coverage for the family may find that practicing part-time comes with one less hurdle. However, physicians who need to find coverage for themselves (or themselves plus family members) may want to look into this early in the decision-making process. To get a quick idea about what is available by state and at what cost, check out www.ehealthinsurance.com. Keep in mind, though, that those with pre-existing health problems may find only limited coverage or may be looking at premiums that cause sudden sticker shock.

Secure disability insurance. Many physicians may ask themselves, "What would happen if I became ill and couldn't work for a year or more?" Especially for those who have a mortgage and a family to care for, disability insurance is an essential. But it's not as straightforward as some might think. Chuck Krugh, Certified Financial Planner and President and CEO of Doctor Disability Insurance in Lake Forest, Calif., reminds physicians that most disability policies require the applicant to be working at least 30 hours a week at the time the policy is purchased. Check out www.doctordisability.com and www.protectyourincome.com to learn more about the ins and outs of disability insurance and how to purchase it.

responsibility, but Dr. Dearmin relishes the experience.

"When my older child turned six, I thought 'six times three is eighteen—he'll be gone before I know it!'" she says. "But with the time we spend together now, I don't have that feeling of surprise with each birthday. I feel I know where the time went. I was there."

It's helpful to conduct a thorough evaluation of personal or family finances before going part-time. Physicians may want to start by taking a close look at their lifestyles. Earning less does not necessarily mean living frugally or depriving oneself of anything truly valued. It might mean prioritizing and becoming creative, which can be a developmental experience in itself.

Time Management

When thinking about scheduled work hours, it's important to be realistic. What does a half-day really mean? Physicians commuting an hour or more each way to work a four-hour shift are looking at "working" for the better part of a day—for only a half-day of income. For most part-time physicians, working full days is the best option. Dr. Alguire of the ACP wrote in an article recently: "Working only part of a day soon leads to dissatisfaction as the four-hour commitment stretches to five or six hours. If at all possible, arrange to work full days to minimize 'work creep,' but at the same time remain flexible to the needs of the group to cover unexpected problems and unanticipated patient demand."

Whether staying with the current group or employer, or embarking on a new position in a new setting, it's in the physician's best interest to carefully negotiate the part-time contract. "If you are working part-time, pay particular attention to how the agreement defines your schedule," says Ohio-based healthcare consultant Jack Valancy. Items that should be clearly outlined include work hours, coverage locations (i.e., offices and hospitals), the call schedule, and committee responsibilities.

Another factor is how patients will respond to a new schedule, especially if they've grown accustomed to having their physician in the office five days a week. Solo physicians working part-time should consider how to staff the office and be available for after-hours calls. Physicians in a partnership or group will need the buy-in of their colleagues to make the part-time position work.

But as long as patients can get the care they need in a timely manner, it's likely that most will be perfectly happy with a part-time doctor.

Although most physicians who decide to cut back have something in mind for their freed-up hours, the change can set off a bit of an identity crisis. Some physicians may ask themselves, "Who am I now that I'm not 'in demand' around the clock?" Having more time sounds blissful to someone who is dashing from here to there, never slowing down, too busy to breathe or have a moment alone. But once that time is available, there is often uncertainty about how to fill it.

"The medical training and education of physicians emphasize the power of doing, rather than the power of being," says physician/career coach Dr. Moskowitz. "As a result, most physicians are uncomfortable in situations in which they are not achieving or doing something." Dr. Moskowitz says the first step is simply granting oneself permission to *be*. "It's not only okay, it's the way we recharge our batteries," he says. "Eventually the discomfort goes away, and physicians naturally discover things they want to do to fill time—things that are not competitive or achievement oriented, but just fun or satisfying."

Getting the Financial House in Order

Working part-time will most likely mean a reduction in income. Going from 100 percent to 80 percent time may not have a significant impact on most physicians' lifestyles, but for those who want to cut their work hours more dramatically—say, down to 50 percent or less—factoring in finances is important.

There are a number of important things to consider and put into place. There are expenses involved with being a physician, and full-time workers typically get many of them covered by their group or employer. Physicians scaling back their hours should find out ahead of time which of the following they'll need to cover on their own:

- State medical license, DEA, and specialty board fees
- Continuing medical education
- Hospital privilege reappointment application fees
- Subscriptions to medical journals and online publications
- Cell phone, pager

- Association and medical society membership fees
- Professional liability insurance. Check with the current carrier about part-time policy options, and be sure to have tail coverage in place if changing jobs to go part-time.

Independent contractors (those who receive a 1099 form instead of a W-2) are also responsible for paying their own taxes, including self-employment tax. Part-time employees may not

Retiring . . . Without Really Retiring

When and how to retire from the active practice of medicine are monumental decisions for most physicians. Having trained extensively—both during the early days of formal training and then throughout the career cycle—and devoted decades to establishing and then managing an engaging and demanding career, how does a physician know when it's time to close the doors to the practice? One way to make the decision easier is to leave the door ajar.

Obstetrician/gynecologist Thomas F. Purdon, MD, of Tucson, Ariz., was certain—after a long career in a multi-specialty group practice in Colorado and then 15 years at the University of Arizona—that he was ready to step away from working full-time. Still, he wasn't ready to exchange his black bag for a golf bag. Not completely, anyway.

Two years ago he left his position at the university and quickly stepped into two new roles that meet his need for both intellectual stimulation and connecting with patients. A day and a half each week, Dr. Purdon works as a gynecology consultant at the local primary care community health clinic.

One issue faced by physicians who want to continue seeing patients on a less-than-full-time basis is what to do about malpractice insurance. "It's a sad situation," says Dr. Purdon, "that we have these talented physicians who are being limited in what they can do because of the professional liability problem we have." Dr. Purdon is covered at the community clinic by federal tort claim insurance.

Dr. Purdon still lectures medical students at the University and also travels extensively, speaking on behalf of two pharmaceutical companies and a medical device company. "I always like getting out, talking to doctors."

"I'm very blessed," continues Dr. Purdon. "The only conflict I have with myself is if I've taken on too much, if I'm going to miss my own retirement, so to speak. But my motivation isn't to try to lower my handicap. I feel more comforted by giving back."

quality for their organizations' retirement plan; that is something else to factor into decision making, especially if the employer offers matching contributions.

It's helpful to conduct a thorough evaluation of personal or family finances before going part-time. Physicians may want to start by taking a close look at their lifestyles. Earning less does not necessarily mean living frugally or depriving oneself of anything truly valued. It might mean prioritizing and becoming creative, which can be a developmental experience in itself.

For the Dearmin family, the modest financial curtailments they've made have been well worth the effort. The couple is practical, responsible, and, as Dr. Dearmin says, "rich in the ways that matter." She credits reading *Your Money or Your Life*, by Joe Dominguez and Vicki Robin, with bolstering her confidence to cut back to working part-time. "People have a lot of financial fears," says Dr. Dearmin. "We're not making concessions except ones that allow us to enjoy the dividends of the life we live. We're more attentive to knowing where our money is going." The family has financial contingency plans in place, including savings and both health and disability insurance.

Dr. Dearmin keeps a close eye on finances by doing her own taxes. This, she says, not only saves money but also helps her better understand and take advantage of the business deductions she's allowed as a sole proprietor.

According to Dr. Moskowitz, addressing finances is a critical factor for the physician who is contemplating cutting back to part-time work. "The decision affects the entire family system including the spouse, children, and possibly even dependent parents," he says. "Everyone needs to be considered."

When working with clients who are re-evaluating their financial lives, Dr. Moskowitz recommends both physician and spouse carry around a small notebook for three months to record what they spend. This, he says, results in "aha" moments when the math is done and they see exactly where their money is going. It helps physicians target areas where they can cut back without feeling deprived or as if they're living in scarcity mode. "Everyone has difficulty downsizing his or her lifestyle. But if you're in firm awareness of your values and purpose and the reasons you've decided to downsize, then the commitment becomes easier," he says.